

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZA BETH J. ABBOTT			2a. DATE OF DEATH MONTH DAY YEAR DEC 27 '83			2b. HOUR 7:15AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept 17 1909		6. AGE (IN YEARS LAST BIRTHDAY) 74		7. IF UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Retail			
13a. STATE Virginia		13b. COUNTY Prince William		13c. CITY OR TOWN Manassas		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8305 Highland St.	
14. FATHER'S NAME FIRST MIDDLE LAST Gordon Emmett Bevers		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jasper E. Ratteree		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					
16b. SOCIAL SECURITY NO. 214-30-2326		17. INFORMANT ADDRESS Charles B. Abbott (son) see #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary infarct 5602 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) clot - intestinal obstruction DUE TO, OR AS A CONSEQUENCE OF (c) volvulus - ileum 5602								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate days "	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY, ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/26/83 to 12/27/83 , that (I) (we) lost saw the deceased alive on 12/26/83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not) view the body after death.									
22b. SIGNATURE Thos G. Ward		DEGREE MD		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/27/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward		22e. ADDRESS 6116 Robinson Rd, Bethesda, MD 20817							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 27, 1983		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 9 - 1984		25b. REGISTRAR'S SIGNATURE John J. Connel			



20% POLYMER
11/11/11

Alcohol
100% 100%

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1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) CHARLOTTE MARIE ABEL			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 5 1983			2b. HOUR 6:58 P_M					
3 SEX FEMALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 24 1942		6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		8. IF UNDER 24 HRS. HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISCONSIN		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE		12b. KIND OF BUSINESS OR INDUSTRY Medical			
13a. STATE VIRGINIA		13b. COUNTY FAIRFAX		13c. CITY OR TOWN BURKE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5705 WOODEN HAWK LANE 99999			
14. FATHER'S NAME FIRST MIDDLE LAST GERALD ROBERT JELINEK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHRYN DERILLA COBURN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 391-40-4847		17. INFORMANT ADDRESS JOSEPH A. ABEL, 5705 WOODEN HAWK LANE, BURKE, VA 22015					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1749 RECURRENT BREAST CARCINOMA WITH BRAIN AND LUNG METASTASES DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 20, 1983 , to DECEMBER 5, 1983 , that (I) (we) last saw the deceased alive on DECEMBER 5, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Schwartz</i>			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6 DEC 1983		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAUL S. SCHWARTZ, LT, MC, USNR			22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/transit			23b. DATE Dec. 7, 1983		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Milwaukee Wisconsin			
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey			ADDRESS Bethesda, Maryland			25a. DATE REC'D. BY REGISTRAR DEC 7 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Coburn</i>		

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BP

Checked by Medical Examiner

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Albert Abramson					12 06 83	
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Male			White		05 10 01	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
RUSSIA			USA		82 Years old	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Silver Spring			Holy Cross Hospital		Montgomery County MD.	
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. CITY OR TOWN		13b. STREET ADDRESS	
13a. STATE			13b. CITY OR TOWN		13c. STREET ADDRESS	
Maryland			Montgomery		Silver Spring	
14. FATHER'S NAME (FIRST MIDDLE LAST)			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
SAMUEL ABRAMSON			KATIE ENGEL		NO	
17. INFORMANT			18. SOCIAL SECURITY NO.		19. DATE OF DEATH	
ETHEL ABRAMSON, SILVER SPRING, MARYLAND			079-12-2656 A		1220 EAST WEST HIGHWAY	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			21. IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
			BILATERAL ASPIRATION PNEUMONIA		1-2 DAYS	
			CEREBRAL VASC. ACCIDENT		18 MONTHS	
			CEREBRAL ARTERIOLENTIC DISEASE		INDEFINITE	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:			22. PARALYSIS DISEASE - FEEDING GASTROSPHY			
23a. DATE OF OPERATION			23b. CONDITION FOR WHICH OPERATION WAS PERFORMED		24a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			25b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
25a. INJURY OCCURRED			25b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		26a. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
25a. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			25b. PLACE OF INJURY		26a. HOW INJURY OCCURRED	
27a. I certify that (I) (this hospital) attended the deceased from 12/1/83 to 12/6/83, that (I) (we) last saw the deceased alive on 12/1/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.			27b. SIGNATURE		27c. DATE SIGNED	
Lawrence D. Marcus, M.D.			27b. SIGNATURE		12/6/83	
27b. PHYSICIAN'S NAME (TYPE OR PRINT)			27c. ADDRESS		27d. LOCATION	
LAWRENCE D. MARCUS, MD			10313 GEORGIA AVE SILVER SPRING, MD		PRINCE GEORGE'S, MARYLAND	
28a. BURIAL, CREMATION, REMOVAL			28b. DATE		28c. NAME OF CEMETERY OR CREMATORY	
BURIAL			12/7/1983		MOUNT LEBANON CEMETERY	
28d. NAME OF FUNERAL HOME			28e. DATE REC'D. BY REGISTRAR		28f. REGISTRAR'S SIGNATURE	
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME			DEC 9 1983		Don. S. Conrad	
28d. ADDRESS			28e. DATE REC'D. BY REGISTRAR		28f. REGISTRAR'S SIGNATURE	
232 CARROLL STREET, N. W., WASHINGTON, D. C.			DEC 9 1983		Don. S. Conrad	

1970

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nasifeh E. Abuelafia		2a. DATE OF DEATH MONTH DAY YEAR 12-12-83		2b. HOUR 6:40 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 16 1928	
6. AGE (IN YEARS LAST BIRTHDAY) 55		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Palestine		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Shady Grove		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Practical Nurse	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS 12004 Winesap Terrace			
13b. STATE Maryland		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Abdulrahman Ayesha Wahdan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Watfa Hasan Husein			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 194-46-0010		17. INFORMANT Mofid A. Wahdan	
				12004 Winesap Terrace Gaithersburg, Md. 20878	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **PANCREATIC CARCINOMA.****1579**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Obstruction of Common Bile duct.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from December 7, 1983 , to December 12, 1983 , that (I) (we) last saw the deceased alive on December 12, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Gregory H. Fisher M.D.				DEGREE M.D.		22c. DATE SIGNED 12/13/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory H. Fisher				22e. ADDRESS 13-15 East Deer Park Drive Gaithersburg, Maryland.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/15/83		23c. NAME OF CEMETERY OR CREMATORY Islamic Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS Colonial Funeral Home Falls Church Va 22044				25a. DATE REC'D. BY REGISTRAR DEC 20 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

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BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A 15 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.
1. DECEASED NAME (TYPE OR PRINT) Margot A. Agramonte						2a. DATE KNOWN OF DEATH MONTH 12 DAY 26 YEAR 1983		2b. HOUR A M		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 11 DAY 1 YEAR 1902	6. AGE (IN YEARS) LAST BIRTHDAY 81 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN 	2c. DATE PRONOUNCED DEAD MONTH 12 DAY 26 YEAR 1983		2d. HOUR 7 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH POTOMAC		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11503 KAREN DRIVE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN POTOMAC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11503 KAREN DRIVE		
14. FATHER'S NAME FIRST Leopoldo MIDDLE G. LAST Abreu			15. MOTHER'S MAIDEN NAME FIRST Dolores MIDDLE LAST Sanchez							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 109-36-5035		17. INFORMANT ADDRESS Md. Ernest L Daly. 11503 Karen Dr., Potomac,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 3310 IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ALZHEIMER'S DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE 10-15 YRS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION 			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH AA 12 26 1983			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12 26 1983			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) DIED IN BED				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21f. LOCATION STREET 11503 KAREN DR. CITY OR TOWN POTOMAC COUNTY MONT. STATE MD				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion										
ACTUAL SIGNATURE Francis C. Mayle M.D.						TITLE (SPECIFY) DEPT		MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C. MAYLE						ADDRESS 8200 Wisconsin Ave		DATE SIGNED 12/26/83		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/29/1983		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN Woodlawn COUNTY Bronx STATE New York			
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. NAME 5130 Wisc. Ave., N.W. Wash., D.C.						25a. DATE REC'D. BY REGISTRAR JAN 03 1984		25b. REGISTRAR'S SIGNATURE John J. Galt		

x

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Harriett Edna Okers				2a. DATE OF DEATH MONTH DAY YEAR 12-28-83			
3. SEX Female				2b. HOUR 3:30 A.M.			
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 18 1896		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher Ret. School		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR M. HILTY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA MAE SLABIE		13e. STREET ADDRESS 3005 McComas Ave.		13f. 2089D	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 172-18-5949		17. INFORMANT Mrs. Lora Tekesh, Dtn Kensington Md 20885		ADDRESS 3005 McComas Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia 4409 DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic vascular disease DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from DEC 27 , 19 78 , to DEC 28 , 19 83 , that (I) was did saw the deceased alive on DEC 27 , 19 83 , and that in (my) last last opinion death occurred on the date and hour and from the causes stated above, (I) was did (did not) view the body after death.							
22b. SIGNATURE Walter E. Gooch MD				DEGREE MD		22c. DATE SIGNED DEC 28, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOCH MD				22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE Dec 29, 1983		23c. NAME OF CEMETERY OR CREMATORY Chambers Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Riverdale P.O. City Maryland	
24. FUNERAL DIRECTOR NAME W.N. Chambers Co. 8655 Co. Ave. S.S. Md 20910				25a. DATE REC'D. BY REGISTRAR JAN 4 1984			
				25b. REGISTRAR'S SIGNATURE John J. Conner			

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										33538 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROGER ALAIN AMSELLEM							2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12 12 1983		2b. HOUR AM PM AM		
3. SEX Male		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 3 11 44		6. AGE (IN YEARS) LAST BIRTHDAY 39 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 13 1983		7d. HOUR AM PM PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Fes Morocco			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY		
10. CITY OR TOWN OF DEATH ROCKVILLE			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5930 DORCHESTER WAY				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HAIRDRESSER		12b. KIND OF BUSINESS OR INDUSTRY Store Owner		
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5930 DORCHESTER WAY			
14. FATHER'S NAME FIRST MIDDLE LAST Sholom Amsellem						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Amsellem					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 579-58-6672		17. INFORMANT ADDRESS Potomac, Md. 20854 Claude Amsellem, 10716 Barnwood Lane;					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HANGING DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION —				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR AM P.M. 12 12 1983				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) HUNG IN BASEMENT LAUNDRY			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5930 DORCHESTER WAY ROCKVILLE MONT. MD							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Francis C. Marie						TITLE (SPECIFY) Dept		MEDICAL EXAMINER		DATE SIGNED 12/13/83	
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Marie						ADDRESS 8200 WISCONSIN AVE BETHESDA					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/14/83		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi; Prince George's; Md.			
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS						25a. DATE REC'D. BY REGISTRAR DEC 16 1983					
1170 Rockville Pike; Rockville, Maryland 20852						25b. REGISTRAR'S SIGNATURE John J. Gault					

MEDICAL CERTIFICATION

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John Paul Arnaud			2a. DATE OF DEATH MONTH DAY YEAR December 20, 1983			2b. HOUR A 12:20 M					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 1, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6010 McKinley Street				12a. USUAL OCCUPATION Communications Engineer		12b. KIND OF BUSINESS OR INDUSTRY Communications			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6010 McKinley Street 20817	
14. FATHER'S NAME FIRST MIDDLE LAST Theodore Arnaud				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gabrielle Andrea Leclerc							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 124 28 2926		17. INFORMANT ADDRESS Lydia D. Arnaud Wife same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the Prostate 1850 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from October 13, 19 83, to December 20, 19 83, that (I) (we) lost saw the deceased alive on December 15, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard Holt MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-20-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Holt, M.D.						22e. ADDRESS 3800 Reservoir Rd. Washington, D.C.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Dec. 23, 1983		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY Alexandria Virginia				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR DEC 22 1983		25b. REGISTRAR'S SIGNATURE John J. [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) RAYMOND L. ASHLEY						2a. DATE OF DEATH MONTH DAY YEAR 12-22-83		2b. HOUR 12:20 A			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 21 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.					
10. CITY OR TOWN OF DEATH GAITHERSBURG		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HERMAN WILSON HEALTH CARE Ctr				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Elec. Engineer		12b. KIND OF BUSINESS OR INDUSTRY Balt. gas & Elec.co.			
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 401 Russell Ave. #103			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Wesley Ashley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Grace McDaniel		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No							
16a. SOCIAL SECURITY NO. 212-05-6405A		17. INFORMANT Millicent Ashley				ADDRESS Gaithersburg, Md. 20877					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POSSIBLE GASTRIC OUTLET OBSTRUCTION 3310 DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE ALZHEIMERS DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) ARTEROSCLEROTIC HEART DISEASE PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from Nov 16 , 19 83 , to Dec 22 , 19 83 , that (1) (we) last saw the deceased alive on Dec 8 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE James R. Moore Jr. MD				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-22-83			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) James R. Moore Jr. MD				22d. ADDRESS 207 Brookes Ave Gaithersburg Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/24/83		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Balt. Md.		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME Gartner Sandison F.H.		ADDRESS 316 E. Diamond Ave. Gaithersburg, Md. 20877		25. DATE REC'D. BY REGISTRAR DEC 28 1983		25. REGISTRAR'S SIGNATURE James R. Moore Jr.					

20% COTTON

CHIEF-CLERK



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4. fourth of these is the fact that the
5. fifth of these is the fact that the

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|---|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Jesse St. Claire Baggett | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 17, 1983 | | | 2b. HOUR
5:30A M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 14, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Owner | | 12b. KIND OF BUSINESS OR INDUSTRY
Self Employed | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
Maryland | | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Mitchellville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jesse F. Baggett | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jessie Alexandria Munro | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes W.W. II | | | |
| 16b. SOCIAL SECURITY NO.
577-03-3865A | | | 17. INFORMANT
Mrs. Frances S. Baggett | | | Address Address Same as No# 13c. | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

1629

IMMEDIATE CAUSE (a) **CARCINOMA OF LUNG**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> , 19 <u>83</u> , to <u>12/17</u> , 19 <u>83</u> , that (I) (we) lost
saw the deceased alive on <u>12/16</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Kirkland C. Brace</i> | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/17/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KIRKLAND C. BRACE | | 22e. ADDRESS
1600 CARROLL AVE TAKOMA PARK | | | | | |

| | | | | | | | |
|--|--|-----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 20, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | |
| 24. FUNERAL DIRECTOR
NAME
F. Gasch's Sons F.H. P.A. Hyattsville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1983 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Carver</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, or to the funeral home, if the deceased was taken to the funeral home within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Washington, D.C. 20535
November 1, 1964
Dear Mr. Tolson:
Enclosed for you are two copies of a letterhead memorandum (LHM) dated and captioned as above. The LHM was prepared by the Federal Bureau of Investigation (FBI) and is being furnished to you for your information and guidance. The LHM contains information regarding the activities of the Communist Party, U.S.A., and its efforts to infiltrate the Federal Government. The information was obtained from a confidential source who has provided reliable information in the past. The LHM is being furnished to you for your information and guidance. The LHM contains information regarding the activities of the Communist Party, U.S.A., and its efforts to infiltrate the Federal Government. The information was obtained from a confidential source who has provided reliable information in the past. The LHM is being furnished to you for your information and guidance.

Very truly yours,
J. Edgar Hoover
Director, Federal Bureau of Investigation
Enclosure

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Fred Douglas Bailey | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 21, 1983 | | 2b. HOUR
4:20p M | |
| 3. SEX
Male | 4. RACE
Negro | 5. DATE OF BIRTH
MONTH DAY YEAR
June 20, 1933 | 6. AGE (IN YEARS LAST BIRTHDAY)
50 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Tennessee | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Clinical Center, NIH, Beth., Md. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U.S. Army Ret. | | 12b. KIND OF BUSINESS OR INDUSTRY
ARMY | |
| 13a. STATE
Virginia | 13b. COUNTY
Alexandria | 13c. CITY OR TOWN
Alexandria | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
6903 Quander Road | | 22307 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Leonard Bailey | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Frances Lane | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes Vietnam | | 16b. SOCIAL SECURITY NO.
408-44-1559 | | 17. INFORMANT
ADDRESS
Mrs. Shirley Bailey (wife) Same as Pt. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>T-Cell Lymphoma - with</u>
<u>2028</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Meningeal Involvement</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Klebsiella Pneumonia</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>November 14</u> , 19 <u>83</u> , to <u>December 21</u> , 19 <u>83</u> , that <u>we</u> (we) last saw the deceased alive on <u>December 21</u> , 19 <u>83</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, or (we) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>Robyn D. Rothstein</u> | | DEGREE
MD | | ATTENDING MEDICAL STAFF
PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/21/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBIN D. ROTHSTEIN | | 22e. ADDRESS
National Institutes of Health
Clinical Center, Bethesda, Md. 20205 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-27-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Va. |
| 24. FUNERAL DIRECTOR
NAME
Marshall's Funeral Home | | 24b. ADDRESS
4217 9th Street NW: Washington, D.C. | | 25. DATE REC'D. BY REGISTRAR
DEC 28 1983 | | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Canfield</u> | | | | |

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20% COL 10M



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Howard McCoy Baines | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-3-83 | | | 2b. HOUR
6:45 AM | | | |
| 3. SEX
M | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 23, 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Retired | | | |
| 10. CITY OR TOWN OF DEATH
Maryland | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Takoma Park Seventh Day Adv. Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
District of Columbia | | 13b. COUNTY
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS
1458 Columbia Road, N.W. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Howard Baines | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nettie Rogers | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
577 24 8835 | | 17. INFORMANT ADDRESS
Fulies Baines-brother-1817 Varnum St. | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardio Respiratory arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Intera Cerebral Hemorrhage**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Severe Hypertension**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/12/1983 , to 12/2/1983 , that (I) (we) last saw the deceased alive on 12/2/1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Tony P. Kannerkat MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/3/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Tony P. Kannerkat | | | | 22e. ADDRESS
8201 16th St S-S. MD 20910 | | | |

| | | | | | | | |
|--|--|---------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
Dec 9, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Maryland National Cemetery Laurel, Md | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
Stewart Funeral Home-4001 | | | | 25. REG. NO. 5-1983 REGISTRAR'S SIGNATURE
John S. Stewart | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Mary R. Baker | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 31 83 | | | |
| 3. SEX
Female | | | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
12 12 04 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
79 | | | | IF UNDER 1 YEAR MONTHS DAYS
YRS. | | IF UNDER 24 HRS. HOURS MIN.
6:50p M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Clerk | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. STREET ADDRESS
2601 Bel Pre Road 20906 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
577-05-8958 | | 17. INFORMANT C. H. Hilliard (Cousin) ADDRESS
5407 J. Roland Avenue Balto. Md. 21210 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive CVA
4360
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 days | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Anemia 2° UGT Bleeding | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 22 19 83 to Dec 31 19 83 , that (I) (we) lost saw the deceased alive on Dec 31 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Daniel L. Anderson MD | | | | DEGREE
MD | | 22c. DATE SIGNED
1/1/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Daniel L. Anderson MD | | | | 22e. ADDRESS
18111 Pr. Philip Dr. Olney Md 20832 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1/5/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Carmel Ch. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Sunshine Md. | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home, Inc 1331 Rockville Pike Rockville, Maryland 20852 | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 6 1984 | | 25b. REGISTRAR'S SIGNATURE
Joan J. Canine | |

NO _____ 577-05-8253 5401 J. Roland Avenue Hells, Md. 21220
 C. F. Lillard (County)

Maryland Montgomery Silver Spring 2601 2nd Ave Road
 Clerk Retired Clerk
 Maryland U.S.A. Montgomery General Hospital

100%
 100%
 100%
 100%
 100%
 100%
 100%
 100%
 100%
 100%

Burial 1/5/84 W. F. Daniel Ch. Cem. Manassas

1001 Rockville The Rockville, Maryland 20850
 Vernon V. Selzer Trust, Inc.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Holdine F. Balcom | | | | 2b. HOUR 7:25 P.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7 30 03 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | |
| 11. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital 8600 Old Georgetown Rd Bethesda Md | | 12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE D.C. 20016 | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Washington | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alexander McGregor Primrose | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Dellit | | 13e. STREET ADDRESS 4720--44th St., N.W. 99999 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 578-72-6382 | | 17. INFORMANT ADDRESS Robert B. Balcom. Same as item 13. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
4360
DUE TO, OR AS A CONSEQUENCE OF:
(b) right parietal lobe cerebrovascular accident
DUE TO, OR AS A CONSEQUENCE OF:
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: hypertension | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 7 19 83 to Dec 13 19 83 , that (I) (we) lost saw the deceased alive on Dec 13 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Barbara Blaylock, M.D. DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12-13-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barbara Blaylock, M.D. | | | | 22e. ADDRESS Bethesda, Maryland Suburban Hospital 8600 Old Georgetown Rd., | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 12/16/1983 | | 23c. NAME OF CEMETERY OR CREMATORY National Memorial Park Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church Va. | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C. | | | | 24. DATE RECEIVED BY REGISTRAR DEC 20 1983 | | 24. REGISTRAR'S SIGNATURE John J. Gault | |



Lower

U.S.A.

xx

Miss

Bottom

U.S. 20016

Washington

1950-1951, N. A.

Alexander Hamilton

Primrose

Hammond

White

to

1950-1951

about

Handwritten notes and markings on the left side of the page, including a large '7' and various illegible scribbles.

x

Washington Hospital, D.C.

Washington Hospital, D.C.

Bureau

1950-1951

National Memorial Park

National Memorial Park

White Church Co.

Joseph Smith's Home Inc.

2100 Loc. Ave., N.W., Wash., D.C.

Handwritten notes and markings at the bottom left, including '1950-1951' and 'White Church Co.'

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| Ingeborg | | Bang | | 12-4-83 | | 11:05 | | M | |
| 1. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| FEMALE | | WHITE | | MARCH 20, 1902 | | 81 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Norway | | U.S.A. | | | | Montgomery County, MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Rockville | | National Lutheran Home | | clerical worker | | unknown | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Virginia | | Alexandria | | Alexandria | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2854 S. Buchanan Street | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Martinus H. Flyday | | Petra N. Olsen | | no | | 114-30-3259 A | | Rev. Dr. Richard Reichard 9701 Veirs Dr. Rockville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. IMMEDIATE CAUSE (a) | | 20. DUE TO, OR AS A CONSEQUENCE OF (b) | | 21. DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4292 | | C.V.A. | | ASCVD | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 6 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | |
| | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 10/10/83 to 4/10/83, that (I) (we) last saw the deceased alive on 3/10/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Thomas E. Dooley, M.D. | | 12/4/83 | | Thomas E. Dooley, M.D. | | 17904 Georgia Ave. Olney, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY STATE | |
| Burial | | Dec. 7, 1983 | | Maple Grove Cemetery | | New York City, New York | | | |
| 24. FUNERAL DIRECTOR | | 25. DATE REC'D. BY REGISTRAR | | 25. REGISTRAR'S SIGNATURE | | | | | |
| The Hysong Company 1300 N St. N.W. Wash. D.C. | | DEC 12 1983 | | John J. Conner | | | | | |

BP
DHWH-16-50M (7-8)
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked either 18 shows any injury, or other traumatic event, the medical examiner should be notified.

12-11-83 No. 2

Brand

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U.S.A.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|--|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST
Eugene S. Banks | | MONTH DAY YEAR
12-26-83 | | 2:45 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | 7. IF UNDER 1 YEAR | |
| Male | Black | MONTH DAY YEAR
1-02-20 | 63 | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Raleigh, NC | USA | | Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Silver Spring | Holy Cross Hospital | | Janitor | | Private Ind. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | 13c. INSIDE CITY LIMITS? | 13d. STREET ADDRESS | |
| Maryland | | Montgomery | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 8718 Cameron St. #218 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST
Albert Banks | | FIRST MIDDLE LAST
Savannah Burke | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 237-12-4694 | | Silver Spring, Md
Mildred Banks 8718 Cameron St. #218 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) 1629
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

DUE TO, OR AS A CONSEQUENCE OF

(c)

POUR OBSTRUCTIONCANCER OF THE LUNGAPPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 DAYS1 YEAR

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

| | | | | | |
|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from <u>12/26</u> 19 <u>83</u> to <u>1/26</u> 19 <u>83</u> , that (2) I saw the deceased alive on <u>12/26</u> 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (If (we) did not view the body after death. | | 22b. SIGNATURE
<u>Marjorie A. Voith MD</u> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>MARJORIE VOITH MD</u> | | 22e. ADDRESS
<u>106 LIVING ST. NW WASHINGTON, DC</u> | | | |

| | | | |
|--|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | 23b. DATE
<u>12/30/83</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Lincoln Memorial</u> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Suitland PG Maryland</u> |
|--|------------------------------|---|---|

| | | |
|---|--|---|
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<u>R. N. Horton 600 Kennedy St. NW Wash</u> | 25a. DATE REC'D. BY REGISTRAR
<u>AN 09 1984</u> | 25b. REGISTRAR'S SIGNATURE
<u>John J. Conner</u> |
|---|--|---|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of event.



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE GENERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETURN PAGES 1, 2, AND 3 TO THE GENERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED TO THE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | | | |
|--|--|-------------------------|--|---|--|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Carlton Paul Barnes | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12/25/83 | | 2b. HOUR
M 6:10 | | | | | |
| 3. SEX
Male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR Nov. 30, 1964 | | 6. AGE IN YEARS
(LAST BIRTHDAY) 19 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 12/25/83 | | 2d. HOUR
AM 6:10 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
16015 Emory Lane | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Student | | | | 12b. KIND OF BUSINESS OR INDUSTRY
School | | | | | |
| 13a. STATE
Md. 20853 | | | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
4600 Muncaster Mill Rd. | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Paul Robert Barnes | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Gertrude Swope | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES
no | | | | 16b. SOCIAL SECURITY NO.
219-88-4180 | | 17. INFORMANT
ADDRESS
Paul R. Barnes Same as # 13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Stroke and Soot Inhalation
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR 3:15 MONTH DAY YEAR 12/25/83 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
subject in housefire | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
residence | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
16015 Emory Lane, Rockville, Montg., Md. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | | | | | | | TITLE (SPECIFY)
M.D. Assistant | | MEDICAL EXAMINER | | | | DATE SIGNED 12/26/83 | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | | | | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Dec. 29, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Mont. Md. | | | | | | | |
| 24. FUNERAL DIRECTOR
Francis H. Barber Laytonsville, Md. 20879 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 29 1983 | | | | | | REGISTRAR'S SIGNATURE John J. Connel | |

MEDICAL CERTIFICATION

RECEIVED BY THE DIRECTOR OF THE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C.

NOV 21 1963



DEC 23 1963
FBI - NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|---|---|---|--|---|
| 1. FOR STATE REGISTRAR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Dorothy A. Barnes | | | 2a. DATE OF DEATH MONTH DAY YEAR
12-2-83 | | 2b. HOUR
9:15 AM |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH MONTH DAY YEAR
Aug. 6, 1909 | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co., MD. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
Education |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Wesley Adams | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Matilda (Unknown) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
Unavailable | | 17. INFORMANT (daughter) ADDRESS
Bennie Barnes Same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory arrest
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 days | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
diabetes mellitus | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (# EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/26 , 19 83 , to December 2 , 19 83 , that (I) (we) last saw the deceased alive on December 2 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Michael A. Lincoln | | DEGREE
MD. | | 22c. DATE SIGNED
12/2/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael A. Lincoln, MD. | | 22e. ADDRESS
10313 Georgia Avenue Suite 308 Silver Spring Md 20902 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec 6 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Elmwood Cemetery | |
| 23d. LOCATION CITY OR TOWN
Goldsboro, N.C. | | 23e. COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME
Capitol Funeral Service | | ADDRESS
Falls Church, VA | | 25a. DATE REC'D. BY REGISTRAR
DEC 8 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | |

BP

100% COTTON

MADE IN U.S.A.

WASHED & FINISHED

100% COTTON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be retained by the hospital or attending physician.

DHMH - 16 50M 4/82
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
Winifred ANN Barnes | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12-10-83 | | | |
| 3 SEX
Female | | 4. RACE
Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR
1 15 98 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
POTOMAC | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
10432 DEMOCRACY LANE | | 13f. CITY OR TOWN
20854 | | 14. FATHER'S NAME FIRST MIDDLE LAST
WILLIAM HUPPERT | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARY UNKNOWN | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
212-24-4774 | | 17. INFORMANT
ANDREW A. MANDJURIS SON | | 17b. ADDRESS
SAME AS 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4370 Intense chronic Cerebral Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12/9/83 to 12/10/83, that (I) (we) lost the deceased alive on 12/10/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | |
| 22b. SIGNATURE
Robert C. Macon | | | | DEGREE
M.D. | | 22c. DATE SIGNED
12/10/83 | |
| 22d. PHYSICIAN'S NAME (Type or Print)
Robert C. Macon | | | | 22e. ADDRESS
809 Viens Mill Rd. Rockville, Md 20851 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
DEC 13 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
LINCOLN CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BRENTWOOD PR. GEO. MARYLAND | |
| 24. FUNERAL DIRECTOR
FRANCIS J. COLLINS | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | |
| 25c. ADDRESS
500 UNIVERSITY BLVD., W. SILVER SPRING, MD. | | | | | | | |

RECEIVED

TO THE HONORABLE SECRETARY OF THE
NAVY
WASHINGTON, D. C.

DEAR SIR:

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above subject.

Very respectfully,
Your obedient servant,

Wm. H. Hunt

1000 1st St. N. Wash. D. C.

1000 1st St. N. Wash. D. C.

1000 1st St. N. Wash. D. C.



CHIEF OF BUREAU

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
William P Barry | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/16/83 | | | 2b. HOUR
5:19A _M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 21 16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASH., D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
VICE PRES. | | 12b. KIND OF BUSINESS OR INDUSTRY
GIANT BAKERY FOOD | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTG. | | 13c. CITY OR TOWN
BETHESDA | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ANTHONY BARRY | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNIE V. FLEMING | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W.W.11 | | 17. INFORMANT
ANNE H. BARRY | | ADDRESS
SAME AS # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u>
<u>4100</u>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>acute myo cardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF:
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 hr</u>
<u>3 hr</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 16</u> 19 <u>83</u> to <u>Dec 16</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Dec 16</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Dennis J. Donohue MD</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-15-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dennis J. Donohue | | | | 22e. ADDRESS
7600 Carroll Ave
Takoma Park, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12-19-83 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. GABRIEL'S CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
POTOMAC MONTG. MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
JOS. GAWLER'S SONS INC. 5130 WISC. AVE. NW. WASH., D.C. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1983 | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Conner</u> | | | |

BP



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Margaret Joan Bartnik | | | 2a. DATE OF DEATH MONTH DAY YEAR
9 Dec 1983 | | 2b. HOUR
4:10 pm |
| 3. SEX
Female | 4. RACE
Cauc. | 5. DATE OF BIRTH
MONTH DAY YEAR
11 11 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sharon Nursing Home marden Ln 18201 | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
STATE DEPT. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Maryland Prince George's | 13c. CITY OR TOWN
Hyattsville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
5506 Decatur St. 20781 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRANK BARTNIK | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
STELLA PRYCKZK | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
211-12-7230 | | 17. INFORMANT
SON ADDRESS
DAMASCUS, MD. 20872 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
3348
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Respiratory failure & acidosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Spinal cerebellar degeneration
1973 | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
1:30 pm
6 Dec. 1983 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
Muscle wasting | | | | | |
| 19a. DATE OF OPERATION
N.A. | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N.A. | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
N.A. | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 26 Jan 1979 to 9 Dec 1983 , that (I) (we) last saw the deceased alive on 8 Dec 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Albert S Whiting | | DEGREE
M.D. | | 22c. DATE SIGNED
9 Dec 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Albert S Whiting | | 22e. ADDRESS
3933 Pitcairn Pl. Lame, MD 20707 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
DEC. 12, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN CEMETERY SILVER SPRING MONT. MD | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | ADDRESS
500 UNIVERSITY BLVD. W. SILVER SPRING, MD. | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1983 | |
| | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

BP

DHMM - 16 50M 4/78
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | |
|---|---|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) FREDA BASS | | 2a. DATE OF DEATH
MONTH DAY YEAR Dec 8 1983
2b. HOUR 1:59 PM | |
| 3. SEX
Female | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR 9/20/10 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Poland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | 10. CITY OR TOWN OF DEATH
Silver Spring | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Only Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
SALESLADY | |
| 12b. KIND OF BUSINESS OR INDUSTRY
DEPT. STORE | | 13a. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13b. STREET ADDRESS
12630 VIERS MILL ROAD | | 13c. CITY OR TOWN
ROCKVILLE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOSEPH STEINBERG | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
FRUMA WESSLER | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
578-46-5664 | |
| 17. INFORMANT
JACKIE W. LINDSEY | | ADDRESS
Box 108 WELLINGTON PARK ARDEN, NORTH CAROLINA | |
| 18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
4360
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Vascular Accident
DUE TO, OR AS A CONSEQUENCE OF (c) 2 days | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 min
2 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 5 , 19 83 , to Dec 8 , 19 83 , that (I) (we) last saw the deceased alive on Dec 8 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Howard S. Goldstein | | DEGREE
MD. | |
| 22c. DATE SIGNED
Dec 8, 1983 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Howard S. Goldstein | | 22e. ADDRESS
4701 Randolph Rd. Rockville, MD | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/11/1983 | |
| 23c. NAME OF CEMETERY OR CREMATORY
KING DAVID MEMORIAL GARDEN | | 23d. LOCATION
FALLS CHURCH, VIRGINIA | |
| 24. FUNERAL DIRECTOR
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME | | 25. DATE REC'D. BY REGISTRAR
DEC 14 1983 | |
| 26. REGISTRAR'S SIGNATURE
John J. Connel | | 27. REGISTRAR'S NAME
John J. Connel | |

8-11-23

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8-11-23

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|---|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) James T. Benn | | | 2a. DATE OF DEATH MONTH Dec 2 1983 DAY 2 YEAR 1983 | | 2b. HOUR 5:55 AM | | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH January DAY 7 YEAR 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. MONTHS 0 DAYS 0 HOURS 0 MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Investor | | 12b. KIND OF BUSINESS OR INDUSTRY Financial | | | |
| 13a. STATE Pennsylvania | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Jenkintown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST Philip MIDDLE LAST Benn | | | 15. MOTHER'S MAIDEN NAME FIRST Theresa MIDDLE LAST Brunatti | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) | | | 16b. SOCIAL SECURITY NO. 085 18 3587 | |
| 17. INFORMANT (Wife) Margaret B. Benn | | | ADDRESS 383 Stewart Avenue Jenkintown, Pennsylvania | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
0000 IMMEDIATE CAUSE (a) Cardiopulmonary arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Tracheobronchitis
(c)
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min.
3 days. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Severe Central Nervous System Damage due to Subdural Hematomas and Brain Abscesses/Dissections. | | | | | | | | | |
| 19a. DATE OF OPERATION 10 Dec 1983 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Drainage of Subdural Hematomas and Brain Abscesses | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 19 | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 10 Dec 1983 to 2 Dec 1983 , that (1) (we) lost saw the deceased alive on 28 Nov 1983 , and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE James H. Knepschild, MD | | DEGREE | | 22c. DATE SIGNED 2 Dec 1983 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) James H. Knepschild, MD | | | |
| 22e. ADDRESS 4905 Del Ray Ave, Bethesda, Md 20014 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec. 6, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Hillside Cemetery | | 23d. LOCATION CITY OR TOWN Roslyn, Montgomery, PA COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Funeral Homes, P.A. 7557 Wisconsin Ave., Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR DEC 7 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Smith | | | |

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[illegible text follows]

FILED

NOV 20 1964



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|--|-------------------------------|-----------------------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | MONTH DAY YEAR | | MONTHS DAYS HOURS MIN. | |
| CLARENCE H. BENNETT | | 12/18/83 | | 2/3A M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Male | White | March 23 1906 | 77 | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| New Jersey | U.S.A. | | Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Rockville | SHADY GROVE ADVENTIST HOSP | | Standards Spec. | | Standards Co. |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. STREET ADDRESS / ZIP CODE | | |
| Md. 20816 | Montgomery | Bethesda | 5202 Falmouth Road 20816 | | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | | |
| (Unknown) | (Unknown) | | 577-30-4731 | | |
| 17. INFORMANT | ADDRESS | | | | |
| Dorothy G. Bennett. | Same as item 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST, CARDIAC ARREST</u>
4860
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>BILAT PNEUMONIA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>STAPH SEPSIS</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24h
72h
8 days | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>END STAGE RENAL DISEASE</u> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| 12/11/83 | Removal of infected vascular access graft | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>12/10</u> 19 <u>83</u> to <u>12/17</u> 19 <u>83</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>12/17</u> 19 <u>83</u> , and that in (my) <u>(an)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Mark P. Rubin</u> | DEGREE
<u>M.D.</u> | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
<u>12/18/83</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | | | |
| MARK P. RUBIN | 14805 Physicians Lane Rockville MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| Cremation | 12/19/1983 | Cedar Hill Crematory | Suitland Maryland. | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. DATE REC'D. BY REGISTRAR | |
| Joseph Gawler's Sons, Inc.
5130 Wisc. Ave., N.W. Wash., D.C. | | DEC 21 1983 | | John J. Gurnea | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR OFFICE. RETURN PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))

20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|---------|---|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| BILLY JOE BENTLEY | | | 12 22 19 83 | | | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | 7d. HOUR | |
| MALE | WHITE | NOV. 29, 1983 | YRS. | MONTHS | DAYS | 12 22 19 83 | 11:45 a.m. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Md. | | USA | | | | Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Rockville | | Shady Grove Adventist Hosp. (DOA) | | | | N/A | | N/A |
| 13a. STATE | | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | 20842 | |
| Md. 20842 | | | Mont. | Dickerson | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 23000 River Road | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Robert Bentley | | | Leona Mowell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| no | | | None | | | Robert Bentley Same as # 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome
7980
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | |
| Ann M. Dixon, M.D. | | | M.D. Assistant MEDICAL EXAMINER | | | 12-23-83 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | |
| Ann M. Dixon, M.D. | | | 111 Penn St., Balto., Md. 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | | Dec. 24, 1983 | | Laytonsville | | Laytonsville Mont. Md. | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| FRANCIS H. BARBER LAYTONSVILLE, MD. 20879 | | | | | DEC 28 1983 | | John J. Conner | |

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows in several lines]

RECEIVED
JAN 10 1964



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Charles L Benton | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 25, 1983 | | | 2b. HOUR
9:00a M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
January 18, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5900 Lemay Rd. Rockville, Md. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Emanuel Benton | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
May Richey | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | |
| 16b. SOCIAL SECURITY NO.
193-10-4133 | | 17. INFORMANT Judy Grimes ADDRESS
12800 Leahy Drive Rockville, Maryland | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Ventricular FibrillationAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**11 minutes**

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

Myocardial Ischemia**11 minutes**

DUE TO, OR AS A CONSEQUENCE OF

Coronary Heart Disease**years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Multiple Pulmonary Emboli

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 12 , 19 73 , to Dec 25 , 19 83 , that (I) (we) last
saw the deceased alive on Dec 19 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not view the body after death). | | | | | | | |
| 22b. SIGNATURE
Harris M. Kenner MD. | | | | DEGREE
ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-25-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Harris M. Kenner | | | | 22e. ADDRESS
10401 Old Georgetown Rd. Bethesda, Md. 20814 | | | |

| | | | | | | | |
|---|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-28-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery Silver Spring Mont. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Mont. Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Tyson Wheeler Funeral Home, Inc,
1331 Rockville Pike Rockville, Maryland 20852 | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 3 1984 | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or the medical examiner's assistant should be notified at once.

BP

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506

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DMMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|---------------------|---|---|---|--|---|--|---|--|---|--|--------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Gathering E. Bergman | | | | | | 2a. DATE KNOWN OF DEATH
MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> Dec 29 1983 | | | | 2b. HOUR <input checked="" type="checkbox"/> MIN <input checked="" type="checkbox"/> SEC <input checked="" type="checkbox"/> 8 0 0 | | | |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> Nov 24 1929 | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 54 YRS. | IF UNDER 1 YR.
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS.
HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD
MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> Dec 29 1983 | | | | 2d. HOUR <input checked="" type="checkbox"/> MIN <input checked="" type="checkbox"/> SEC <input checked="" type="checkbox"/> 8 0 0 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Georgia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mont. General Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Exec. Secretary | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE MD. COUNTY Mont. CITY OR TOWN Rockville | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS
14843 Bzuer Dr 20853 | | | | | |
| 14. FATHER'S NAME
FIRST John MIDDLE A LAST Freeman | | | | 15. MOTHER'S MAIDEN NAME
FIRST Elizabeth MIDDLE White LAST White | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | (IF YES, GIVE WAR OR DATES)
----- | | 16b. SOCIAL SECURITY NO.
260-07-4044A | | 17. INFORMANT Walter J. Bergman
ADDRESS 7617 Warbler Lane Derwood, Md. 20855 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Disi
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers | | | | TITLE (SPECIFY) MD. | | | | MEDICAL EXAMINER | | | | DATE SIGNED Dec 29 1983 | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers | | | | ADDRESS 1919 Seminary Rd. Silver Spring, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Cremation | | 23b. DATE
12/31/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | | | 23d. LOCATION
CITY OR TOWN Suitland Maryland COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR
NAME Tyson Wheeler Funeral Home, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 6 1984 | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | | | | | |
| 1331 Rockville Pike Rockville, Maryland 20852 | | | | | | | | | | | | | |

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1997-1998

1331 Rockville Pike, Baltimore, Md. 21201

RJ

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|--|---|--|--|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| JERRY CHARLES BERGNER | | | December 26, 1983 | | | 2:55p M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | |
| Male | White | July 26, 1949 | 34 | | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | |
| Amarillo, Texas | USA | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| | | Montgomery County MD | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | NIH, The Clinical Center | | Administrator | | | Church | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | | |
| New York | | | New York | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | | | | |
| John Carl Bergner | | Lucile Oakley | | 184 Bleecker Street 10012 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | |
| No | | None | | Mrs. Luetta Oakley (Mother) Amarillo, Tx 79109 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | |
| IMMEDIATE CAUSE (a) Numerous micro infarcts in kidneys | | | | | | | | |
| 2791 | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (b) Severe hemorrhagic pneumonitis | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) AIDS/Kaposi's sarcoma | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 4, 1983, to December 26, 1983, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on December 26, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED |
| Michael A. Bockman M.D. | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 12-27-83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | |
| Michael A. Bockman | | | | | | National Institutes of Health, 9000 Rockville Pike, Bethesda, Maryland 20205 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | |
| Cremation | | Dec. 28, 1983 | | Chambers Crematory | | CITY OR TOWN COUNTY STATE | | |
| | | | | | | Riverdale, P. G. Cty. Maryland | | |
| 24. FUNERAL DIRECTOR | | | | | | 25. DATE RECD. BY REGISTRAR | | |
| NAME | | | | | | REGISTRAR'S SIGNATURE | | |
| W. W. CHAMBERS CO. 8655 Ga. Ave. SS, Md. 20910 | | | | | | DEC 30 1983 John J. Canfield | | |

TO BE SIGNED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES OF AMERICA

TO THE HONORABLE SECRETARY OF THE INTERIOR
WASHINGTON, D. C.

FROM THE CHIEF OF BUREAU OF LAND MANAGEMENT
SALT LAKE CITY, UTAH

SUBJECT: [Illegible]

[Illegible text follows]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>aka</i> FIRST <i>M</i> MIDDLE <i>MORRIS</i> LAST <i>BERNSTEIN</i>
<i>Morris Bernstein</i> | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>12 29 83</i> | | 2b. HOUR
<i>8:25 P.</i> | |
| 3. SEX
<i>male</i> | 4. RACE
<i>white</i> | 5. DATE OF BIRTH MONTH DAY YEAR
<i>01 14 14</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
<i>69</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
<i>NEW YORK</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Holy Cross Hospital</i> | | 12a. USUAL OCCUPATION
(FLOOR FOR MOST OF WORKING LIFE)
<i>CONTRACTOR</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>FLOORING</i> |
| 13a. STATE
<i>MARYLAND</i> | | 13b. COUNTY
<i>MONTGOMERY</i> | | 13c. CITY OR TOWN
<i>TAKOMA PARK</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>IKE BERNSTEIN</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>BERTHA KAHN</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>110-05-3941</i> | | 17. INFORMANT ADDRESS
<i>CLARA L. BERNSTEIN, 223 GRANT AVENUE, TAKOMA PARK, MARYLAND</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<i>1850</i> IMMEDIATE CAUSE (a) <i>Adenocarcinoma PROSTATE</i>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 1/2 years</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE
STREET | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 15</i> , 19 <i>82</i> , to <i>Dec 29</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>Dec. 29</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Hubert J. Alpert</i> | | DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>Dec. 30, 1983</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>HUBERT J. ALPERT, M.D.</i> | | 22e. ADDRESS
<i>8630 FENTON ST. SILVER SPRING, MD 20910</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
<i>BURIAL</i> | | 23b. DATE
<i>1/2/1984</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>KING DAVID MEMORIAL GARDEN</i> | |
| 23d. LOCATION
<i>FALLS CHURCH, VIRGINIA</i> | | 23e. DATE REC'D. BY REGISTRAR
<i>JAN 5 1984</i> | | | |
| 24. FUNERAL DIRECTOR
<i>DONALD M. STEIN</i> | | HEBREW MEMORIAL FUNERAL HOME
<i>232 CARROLL STREET, N. W., WASHINGTON, D. C.</i> | | 25a. REGISTRAR'S SIGNATURE
<i>John J. Conner</i> | |

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Jan 3 1988

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Samuel Binder</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>12-28-83</i> | | 2b. HOUR
<i>940</i> M |
| 3. SEX
<i>Male</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>8-15-90</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>93</i> | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Poland</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Holy Cross Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Store Owner</i> | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Grocery</i> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | 13c. CITY OR TOWN
<i>Rockville</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
<i>6121 Montrose Road (20852)</i> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Max Binder</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Anna (Unknown)</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>577-40-0956</i> | | 17. INFORMANT ADDRESS
<i>Potomac, Md. 20854</i>
<i>Albert Binder; 10301 Bells Mill Terrace;</i> | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*CARDIO RESISTANTLY ARREST*APPROXIMATE INTERVAL
ONSET AND DEATH

4140
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *ATHEROSCLEROTIC HEART DISEASE**10 YRS.*

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

CHRONIC OBSTRUCTIVE PULMONARY DISEASE, COMMON VENT OBSTRUCTION, TLEAS

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/17</i> 19 <i>83</i> , to <i>12/28</i> 19 <i>83</i> , that (I) (we) last
saw the deceased alive on <i>12/17</i> 19 <i>83</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>Robert L. Rosenberg, MD</i> | | DEGREE
<i>MD</i> | 22c. DATE SIGNED
<i>12/29/83</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>ROBERT L. ROSENBERG, MD</i> | | 22e. ADDRESS
<i>10313 GEORGIA AVE, SILVER SPRING, MD</i> | |

| | | | |
|--|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | 23b. DATE
<i>12/30/83</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Cong. Cemetery</i> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Washington, D.C.</i> |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</i>
<i>1170 Rockville Pike; Rockville, Md. 20852</i> | | 25. DAY RECEIVED BY REGISTRAR (DATE)
<i>JAN 03 1984</i>
REGISTRAR'S SIGNATURE
<i>John J. Connel</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Irene S. Bittner | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 24, 1983 | | | 2b. HOUR
2:30pm | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 27 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
24105 Newbury Road 20879 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas J. Ball | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pearl E. Runner | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
232-54-7079 | | 17. INFORMANT
ADDRESS
Marlene Bond 24105 Newbury Rd. Gaithersburg Md. 20879 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest
4275
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) organic heart disease | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 4275 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
James L. Hecht | | | | | | DEGREE
MD | | 22c. DATE SIGNED
12/24/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Hecht | | | | | | 22e. ADDRESS
Montgomery General Hosp Olney Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12-29-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Bev. Hills Mem. Gardens Westover | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Monongalia W. Va. | | |
| 24. FUNERAL DIRECTOR
NAME
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Maryland 20852 | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 3 1984 | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | |

BP

1987 Nashville, Tennessee, U.S.A.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | |
|--|--|--|--|--|-------------------|------------------------------------|---|--|-----------------------------------|--|------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | |
| ESTELLE B. BLACKWELL | | | | | 12-29-83 | | | | | 5:00 AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | Caucasian | | Dec 9 1891 | | | 92 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Bhade Island | | USA | | | | | Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Rockville | | 11605 Parkedge Dr. | | | | | Housewife | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| MD | | | | Montg. | | Rockville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1200 Old Georgetown Rd. | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| Ezekiel Tucker Brown | | | | Catherine Manning | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | |
| No | | | | 577-60-3301 | | Richard B Blackwell | | 11605 Parkedge Dr Rockville Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> | | | | | | | | | | 1 hr. | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Infarction</u> | | | | | | | | | | 4 days | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>cerebral arteriosclerosis</u> | | | | | | | | | | 17 yrs | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| <u>generalized arteriosclerosis, fatal anemia, severe arterio-sclerosis + myocardial infarction</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. ALLOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | 4th stage of cancer | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/2/83</u> to <u>12/29/83</u> , that (I) (we) lost <u>saw the deceased alive on 12/20/83</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | 22c. DATE SIGNED | | | |
| <u>Stephen N. Jones</u> | | | | | | | | | 12/29/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | | |
| Stephen N. Jones | | | | | | 809 Veirs Mill Rd, Rockville, MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | |
| BURIAL | | | | JAN. 2, 1984 | | ARLINGTON NATIONAL | | | ARLINGTON VIRGINIA | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| FRANCIS J. COLLINS | | | | | | JAN 9 1984 | | | <u>John J. Collins</u> | | | |
| 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. | | | | | | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



20% COTTON FIBER

CHIEFMAN



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SIDNEY BERNARD BLAUFELD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 13, 1983 | | 2b. HOUR
2:45
a.m. | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 19, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Burtonsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3909 Blackburn Lane | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Printer (Ret) | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Burtonsville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rose Landesman | | 16. STREET ADDRESS
3909 Blackburn Lane | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW II 174-05-9064 | | 17. INFORMANT
Evelyn M. Blaufeld; 3909 Blackburn Lane | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
1579 Adenocarcinoma of Pancreas
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 mo |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Liver metastasis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) the hospital attended the deceased from 1 May , 19 83 , to 13 Dec , 19 83 , that (I) have last saw the deceased alive on 20 Nov , 19 83 , and that in (my) the opinion death occurred on the date and hour and from the causes stated above. (I) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Donald E. Dillon M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
12-13-1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Donald E. Dillon, M.D. | | | | 22e. ADDRESS
1811 Prince Philip Dr Olney, Md 20832 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY
Beth Israel Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cedar Knolls, New Jersey | |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | 25. DATE REGD. BY REGISTRAR
DEC 15 1983 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|--|--|
| 1. FOR
STATE
REGISTRAR | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Gordon A. Bodmer | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 14 1983 | | | 2b. HOUR
8¹⁵ P.M. | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 14 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6405 Camrose Terr. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Dry Cleaner | | 12b. KIND OF BUSINESS OR INDUSTRY
Dry Cleaning | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
Md. 20817 | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6405 Camrose Terr. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John W. Bodmer | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ella Lee Goode | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | 16b. SOCIAL SECURITY NO.
577-05-5040 | | | 17. INFORMANT
ADDRESS
Mary Katherine Bodmer. Same as item 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Bronchogenic Carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
1629 | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 hours
20 months | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Jan 81 , to 13 Dec 83 , that (I) (we) last saw the deceased alive on 13 Dec 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Robert C. Haile M.D. | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/19/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert C. Haile, M.D. | | | 22e. ADDRESS
5100 Wisc. Ave., N.W. Wash., D.C. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/17/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph Gawler's Sons Inc. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 20 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Lash | | | | |
| 24. ADDRESS
5130 Wisc. Ave., N.W. Wash., D.C. | | | | | | | | | | |

BP

Dec. 14 1933

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Dec. 14 1933

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HAZEL CRAWFORD BOISE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 28 1983 | | | 2b. HOUR
6:15 PM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 20 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY)
95 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW MEXICO | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1004 KATHRYN RD. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | |
| 12b. KIND OF BUSINESS OR INDUSTRY
DOMESTIC | | | | | | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
COMMODORE PERRY CRAWFORD | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ALICE BRADLEY | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
110-42-0235 | | 17. INFORMANT
ADDRESS
Ms. Mary Cifelli 401 SHERBROOK DR. SILVER SPRING MD 20904 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4140 IMMEDIATE CAUSE (a) arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1983 to 12/28 1983 , that (I) (we) last saw the deceased alive on July 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
A.F. THIBADEAU, MD | | | | DEGREE
MD | | 22c. DATE SIGNED
12/28/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A.F. THIBADEAU, MD | | | | 22e. ADDRESS
707 SHERBROOK DR. SILVER SPRING 20904 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
12-29-83 | | 23c. NAME OF CEMETERY OR CREMATORY
WESTVIEW MEM. PK. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
CATONSVILLE BALTIMORE MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
SLACK FUNERAL HOME Ellicott City, MD | | | | 25a. DATE REC'D. BY REGISTRAR
1984 | | 25b. REGISTRAR'S SIGNATURE
John J. Smith | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before.

BP



Item #5 G586 12/30/83 CW

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|--|---|---|---|----------------------------------|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
John A. BOOKER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-12-83 | | | 2b. HOUR
6:30 PM | | | | |
| 1. SEX
male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 18, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 11. CITY OR TOWN OF DEATH
.S.S. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
9205 New Hampshire Ave | | | | 12a. USUAL OCCUPATION
Griffith Cons. | | 12b. KIND OF BUSINESS OR
Mechanic | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
S.S. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John A Booker | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida M. Kelley | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
579 09 5767 | | 17. INFORMANT
ADDRESS
Dorothy Booker (Wife) Same as 13E | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
4029
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertensive cardiovascular
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) Disease
Hypertension
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
hrs
mins
YRS | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
CVA - previous. | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT HOME | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 7-14 19 83 , to 12-6 19 83 , that (1) (we) lost
saw the deceased alive on 9-8 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (1) (we) (did) (did not) view the body after death. | | | | | | | | 22b. SIGNATURE
John L Ford and and
DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 22c. DATE SIGNED
12/1/83 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN L Ford | | | | | | |
| 22e. ADDRESS
344 University Blvd W
Silver Spring Md 20907 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
SPECIFY
Burial | | 23b. DATE
12/9/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
S.S. Mont. Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi 11800 New Hampshire Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 9 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Smith | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 3 5 6 9

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SARAH ANN BORAK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 18, 1983 | | | 2b. HOUR
1:40p.m. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 1, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Lithuania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Co-owner (Ret.) Grocery | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE
205 Nelson Street | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Nathan Kurland | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Gertrude Kurland | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
----- 577-56-8508 | | 17. INFORMANT
ADDRESS
Falls Church, Va.
Martin Borak; 3338 Glenmore Drive | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>4860</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic melanoma</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>days</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>metastatic melanoma</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>December 1, 1983</u> to <u>December 18, 1983</u> , that (I) <u>was</u> lost
saw the deceased alive on <u>December 18, 1983</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated
above, (I) <u>was</u> (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Barry Hecht</u> | | DEGREE
M.D. | | ATTENDING <input checked="" type="checkbox"/> MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-18-1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARRY HECHT, M.D. | | 22e. ADDRESS
3929 Ferrara Drive; Wheaton, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-19-83 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Gdn. Falls Church Va.
Rockville, Md. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | | | | |

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DEC 21 1983

John J. Gough

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Ethel Bornstein | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 25 83 2b. HOUR 3:10 P.M. | | | |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 1, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CANADA | | 7b. CITIZEN OF WHAT COUNTRY? CANADA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FERNWOOD NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OFFICE MANAGER | | 12b. KIND OF BUSINESS OR INDUSTRY GARMENTS | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPRING | | 13e. STREET ADDRESS 12625 BILLINGTON ROAD 20904 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST DAVID FAINSTEN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH BROOKS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 137-34-1241 A | | 17. INFORMANT ADDRESS SUSAN B. HOFFMAN, 12625 BILLINGTON ROAD, SILVER SPRING, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
1629
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Adenocarcinoma of lung metastatic
DUE TO, OR AS A CONSEQUENCE OF
(c) 18 Months | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 15, 1982 to December 25, 1983 , that (I) (we) last saw the deceased alive on December 15, 1983 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Deborah B Goldberg DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/26/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Deborah B Goldberg | | | | 22e. ADDRESS 1106 Spring St. Silver Spring Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12/27/1983 | | 23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE ALLS CHURCH, VIRGINIA | |
| FUNERAL HOME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C. DEC 29 1983 | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|---|---|---|--|--|--|--------------------------------------|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
ALICE LOUISE BREWER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 19 1983 | | | 2b. HOUR
8:38^P M | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
MAY 23 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
62 | | IF UNDER 1 YEAR
IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, DC | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
SUPPLY OFFICER | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S.GOV'T | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13a. STATE
FLORIDA | | 13b. COUNTY
DUVAL | | 13c. CITY OR TOWN
JACKSONVILLE | | 13e. STREET ADDRESS
P.O. BOX 14078 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
PHILLIP PATRICK QUINN | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ESTHER MARGARET SCHWABEL | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES
NO - | | | | | 16b. SOCIAL SECURITY NO.
578-12-5882 | | 17. INFORMANT ADDRESS
CARL BREWER, COLONIAL HILLS, APT #14, | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1820 INVASIVE ENDOMETRIAL CARCINOMA INVOLVING BOTH URETERS
DUE TO, OR AS A CONSEQUENCE OF COMPLICATED BY ACUTE TUBULAR NECROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 1, 19 83 to DECEMBER 19, 19 83 , that (I) (we) last saw the deceased alive on DECEMBER 19, 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE BH Strand MD | | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
21 DEC 83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B. STRAND, LCDR, MC, USNR | | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
12-24-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Jacksonville Memory Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Orange Park Clay Fla. | | |
| 24. FUNERAL DIRECTOR NAME
Nalley's F.H. Inc. Mt. Rainier, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 28 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

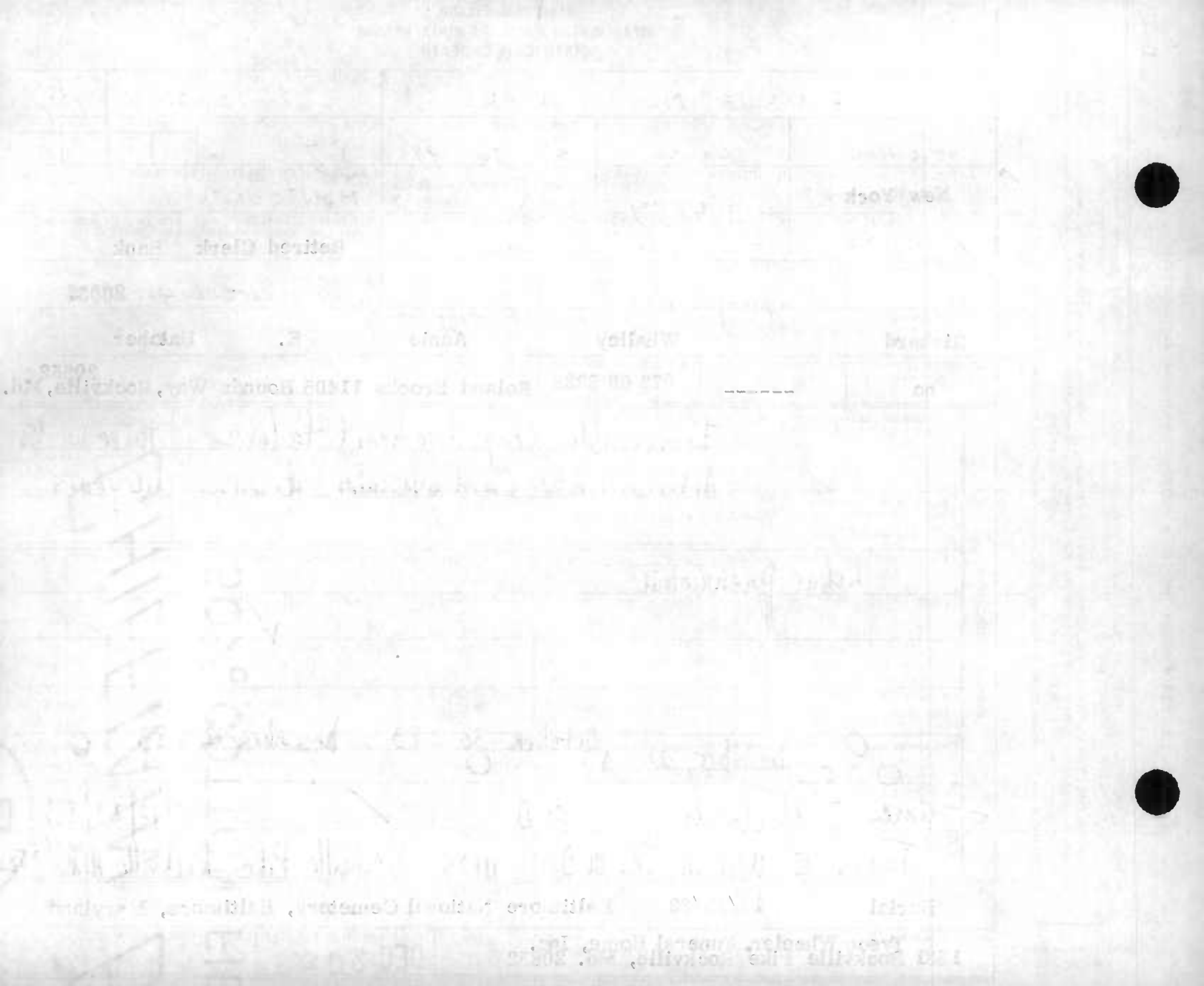
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|----------------------|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 12 | | 22 83 | |
| FLORENCE M. | | BROOKS | | | | | | | | 935 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | White | | MONTH DAY YEAR | | 84 | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| New York | | Montgomery | | | | MONTGOMERY | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| BETHESDA | | SUBURBAN HOSPITAL | | Retired Clerk | | Bank | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Md | | Montgomery | | Beth. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 10290 West Lakes Dr. | | 20034 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| Richard | | Whalley | | Annie E. | | Hatcher | | no | | 072 09 8228 | |
| | | | | | | | | Roland Brooks | | 11405 Hounds Way, Rockville, Md. 20852 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4292
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Irreversible Congestive heart failure
(c) Arteriosclerotic Cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Three weeks
10 years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Lobar Pneumonia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from October 30, 1983, to December 22, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
James E. Wilson, Jr. | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/23/83 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James E. Wilson, Jr. M.D. | | 22e. ADDRESS
1125 Rockville Pike, Rockville, Md. 20852 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 12/28/83 | | Baltimore National Cemetery, Baltimore, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR
Nelson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Md. 20852 | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| | | DEC 30 1983 | | [Signature] | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CHARLES RANDALL BROWN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 8 1983 | | | 2b. HOUR
1:20 P.M. | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
DECEMBER 13 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ALABAMA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. NAVY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY
WASHINGTON, DC | | | | 13b. CITY OR TOWN
NW, WASHINGTON, DC 20016 | | 13c. STREET ADDRESS / ZIP CODE
4000 MASSACHUSETTS AVENUE, NW | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ROBISON BROWN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
STELLA SEED | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
1917-1962 | | 17. INFORMANT
ADDRESS
ELEANOR G. BROWN, 4000 MASSACHUSETTS AVENUE, NW, WASHINGTON, DC 20016 | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIOPULMONARY ARREST**

7294
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **PELVIC FASCITIS, EXTENSION FROM SACRAL DEBRITIS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 2 , 19 83 , to DECEMBER 8 , 19 83 , that (I) (we) lost
saw the deceased alive on DECEMBER 8 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (If (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>B.C. Davis</i> | | | | DEGREE
MD | | 22c. DATE SIGNED
9 Dec 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B.C. DAVIS LCDR, MC, USNR | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | |

| | | | | | | | |
|---|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/12/83 | | 23c. NAME OF CEMETERY OR CREMATORY
US NAVAL ACADEMY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ANNAPOLIS AA MD | |
| 24. FUNERAL DIRECTOR
NAME
TAYLOR FUNERAL CHAPEL | | | | 25a. DATE REC'D. BY REGISTRAR
25b. REGISTRAR'S SIGNATURE
DEC 13 1983 John J. Camera | | | |

15
27
20

THE
OFFICE OF THE
SECRETARY OF THE
NAVY
WASHINGTON, D. C.
JAN 10 1900

TO THE
HONORABLE
MEMBERS OF THE
NAVY

FROM THE
SECRETARY OF THE
NAVY

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR THE SECRETARY OF THE NAVY

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST
Elsie Margaret Brown | | MONTH DAY YEAR
Dec 6, 1983 | | 11 05 A.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| FEMALE | Black | MONTH DAY YEAR
12 28 1924 | | 58 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| D.C. | USA | | | Montgomery Co. MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Montgomery Co. | Washington Adventist Hospital | | House Wife | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS | |
| MD | TOKOMA PARK | | | 6631 NH AVENUE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | |
| Luther Johnson | | Josephine Wood | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS | |
| NO | | 578-64-5144 | | Theodore Brown (Husband) Md.
6631 - NH Ave Tokoma PK | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Septic Shock - Vascular Origin
7855

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5 Days

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

DUE TO, OR AS A CONSEQUENCE OF

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (if (this hospital) attended the deceased from 11-14-1983 to 12-6-1983, that (I/we) lost
saw the deceased alive on 12-6-1983, and that in (my/our) opinion death occurred on the date and hour and from the causes stated
above (I/we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
David Cromwell M.D. | | DEGREE | | 22c. DATE SIGNED
12/7/83 | | 22d. ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
David Cromwell, M.D. | | 22f. ADDRESS
831 Univ. Blvd. E., Sil. Spg., Md. | | | | | |

| | | | |
|---|-------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | 23b. DATE
10 Dec. 83 | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Mem. Park | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Landover, Md. |
| 24. FUNERAL DIRECTOR
NAME Johnson & Jenkins 716 Kennedy St. Wash. D.C. | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1983 | 25b. REGISTRAR'S SIGNATURE
John J. Connel |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or coroner should be notified at once.

1. The first part of the document is a list of names and addresses. The names are: John, Mary, and Peter. The addresses are: 123 Main St, 456 Elm St, and 789 Oak St.

2. The second part of the document is a list of dates. The dates are: 1/1/1900, 2/1/1900, 3/1/1900, 4/1/1900, 5/1/1900, 6/1/1900, 7/1/1900, 8/1/1900, 9/1/1900, 10/1/1900, 11/1/1900, 12/1/1900.

3. The third part of the document is a list of times. The times are: 1:00, 2:00, 3:00, 4:00, 5:00, 6:00, 7:00, 8:00, 9:00, 10:00, 11:00, 12:00.

4. The fourth part of the document is a list of places. The places are: New York, London, Paris, Rome, Berlin, Moscow, St. Petersburg, Constantinople, Cairo, Bombay, Calcutta, Madras, Singapore, Hong Kong, Shanghai, Yokohama, Kobe, Osaka, Manila, Cebu, Iloilo, Zamboanga, Batavia, Surabaya, Medan, Singapore, Penang, Malacca, Port Swettenham, Klang, Seremban, Ipoh, Kuala Lumpur, Johore Bahru, Singapore, Penang, Malacca, Port Swettenham, Klang, Seremban, Ipoh, Kuala Lumpur, Johore Bahru.

5. The fifth part of the document is a list of things. The things are: a book, a pen, a pencil, a ruler, a compass, a protractor, a set square, a pair of compasses, a pair of dividers, a pair of shears, a pair of pliers, a pair of tongs, a pair of forceps, a pair of tweezers, a pair of scissors, a pair of nail clippers, a pair of nail polishers, a pair of nail brushes, a pair of nail files, a pair of nail buffers, a pair of nail polishers, a pair of nail brushes, a pair of nail files, a pair of nail buffers.

David Brown, N.Y. 831 Univ. Blvd. E. 111. 1900.

Johnson, Jenkins 715 Kennedy St. 111. 1900.

In 1900. 111. 1900.

Johnson, Jenkins 715 Kennedy St. 111. 1900.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8 3 3 3 5 7 5 | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Herman S. BROWN | | | | 2a. DATE OF DEATH MONTH DAY YEAR December 29, 1983 | | 2b. HOUR 6:25 A | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 26, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH Mt. Airy | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 28715 Ridge Rd. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Filling Station Operator | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Mt. Airy | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joshua W. Brown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Moxley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 215-32-1267 | | 17. INFORMANT ADDRESS Delma V. Brown, Item 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4292 Anterograde Ischemic
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/15 , 19 72 , to 12/29 , 19 83 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 12/25 , 19 83 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death. | | | | | | | |
| 22b. SIGNATURE James P. Kerr M.D. | | | | DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED Dec. 29, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) James P. Kerr, M.D. | | | | 22e. ADDRESS 26618 Ridge Rd., Damascus, Md. 20872 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec. 31, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Montgomery Meth. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Damascus, Montgomery, Md. | |
| 24. FUNERAL DIRECTOR Olin L. Molesworth, P.A., Damascus, Md. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 3 1984 25b. REGISTRAR'S SIGNATURE John J. Connel | | | |

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861.

2. The second part is a report from the Secretary of the Treasury, dated January 1, 1861, on the state of the Treasury.

3. The third part is a report from the Secretary of the Interior, dated January 1, 1861, on the state of the Interior.

4. The fourth part is a report from the Secretary of the War, dated January 1, 1861, on the state of the War.

5. The fifth part is a report from the Secretary of the Navy, dated January 1, 1861, on the state of the Navy.

6. The sixth part is a report from the Secretary of the State, dated January 1, 1861, on the state of the State.

7. The seventh part is a report from the Secretary of the War, dated January 1, 1861, on the state of the War.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 3 5 7 6

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|--|---|---|---------------------------------|--|--|--|--|-------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE L. LAST BROWN | | | 2a. DATE OF DEATH
MONTH 12 DAY 13 YEAR 183 | | | 2b. HOUR
10 A M | | | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH Sept. DAY 15 YEAR 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Domestic | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Montg | | 13c. CITY OR TOWN
Germantown | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
11030 BRINK Rd. 20874 | | |
| 14. FATHER'S NAME
FIRST William E. MIDDLE B. LAST BROWN | | | 15. MOTHER'S MAIDEN NAME
FIRST Bessie M. MIDDLE J. LAST JENKINS | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | | |
| 16b. SOCIAL SECURITY NO.
218-20-2094 | | | 17. INFORMANT
Dorothy Disney (Sister) | | | | | | ADDRESS
22615 Frederick Rd.
Clarksburg, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF RECTUM
1541
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/20, 1983, to 12/13, 1983, that (I) (we) last saw the deceased alive on 12/13, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
M. C. B. | | | | | | DEGREE
MD | | | 22c. DATE SIGNED
4/13/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KIRKLAND C. BRACE | | | | | | 22e. ADDRESS
7600 CARROLL AVE TAKOMA PARK | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12-17-83 | | | 23c. NAME OF CEMETERY OR CREMATORY
JOHN WESLEY Cem. | | | 23d. LOCATION
(CITY OR TOWN)
CLARKSBURG MONTGOMERY MD. | | |
| 24. FUNERAL DIRECTOR
NAME George R. Snowden | | | | | | ADDRESS
246 N. Wash. St.
Rockville, Md. | | | 25. DATE REC'D. BY REGISTRAR
DEC 21 1983 | | |
| 25. REGISTRAR'S SIGNATURE
John J. Carver | | | | | | | | | | | |

BP

RECEIVED
JAN 10 1960

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or letter body.]

DEC 1 1959
[illegible]
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|---|---|-------------------------------|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Norman Edward Budd | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 30, 1983 | | | 2b. HOUR
2:30 P.M. | | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 23, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69
YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Brinklow | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
18705 Brooke Road 20862 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Norman Budd | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sadie Matthews | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-14-5521 | | 17. INFORMANT
ADDRESS
Ada Budd (Wife) same as #13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Transition</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Adenocarcinoma of Cecum</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Irradiation Enterocolitis</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>5 hr.</u>
<u>1 mo.</u>
<u>1 year</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Irradiation Enterocolitis</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/30/83</u> to <u>12/30/83</u> , that (I) (we) last saw the deceased alive on <u>12/30/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> DEGREE | | | | | | 22c. DATE SIGNED
<u>12/30/83</u> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>C. H. L. Gordon</u> | | | | | | 22e. ADDRESS
<u>18111 Pk Philip Dr Olney Md 21832</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1-5-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Ash Memorial Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sandy Spring, Montg. Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
George R. Snowden | | | | 24b. ADDRESS
246 N. Washington St.
Rockville, Md. 20850 | | 25a. DATE REC'D. BY REGISTRAR
JAN 6 1984 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

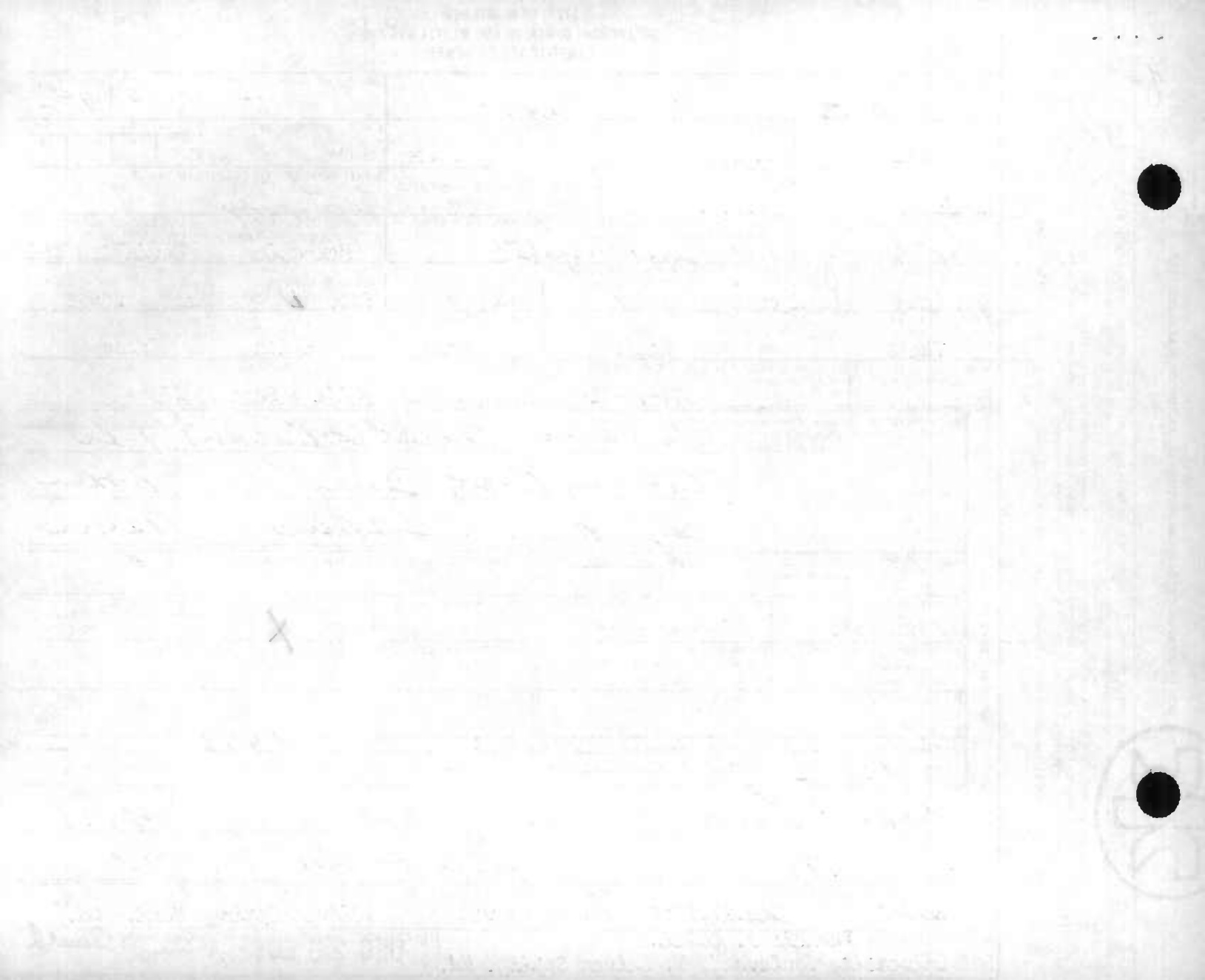
REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Jose Ines Bueso | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-19-83 | | | 2b. HOUR
9:40 A M | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
8-15-23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Honduras | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Only Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY
Covington Buick | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Wheaton | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
The's Reyes | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maria Elisa Bueso | | | 13e. STREET ADDRESS
3220 Midway Street 20902 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
577-50-9298 | | 17. INFORMANT
NAME ADDRESS
Volanda Bueso Wife Same as 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest (Atherosclerosis)
5860
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary Artery Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) Hypertension + Diabetes
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr
8 mon
12 yrs | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
Chronic | |
| 19a. DATE OF OPERATION
12/15/83 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Chronic | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12/15/83 , 19____ to 12/15/83 , 19____, that (I) (we) last saw the deceased alive on 12/15/83 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
R. Collins
THE PHYSICIAN'S NAME (TYPE OR PRINT) | | | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/15/83 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Dec. 21, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Mont. Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Francis J. Collins
500 University Boulevard, W. Silver Spring, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 23 1983
25b. REGISTRAR'S SIGNATURE
John J. Smith | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Joseph J Bunsa | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 31 83 | | 2b. HOUR
6:15p.m. | |
| 3. SEX
Male | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
04 05 13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Boxing Referee | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
DC | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5120 Sargent Road NE 99999 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
August J. Bunsa | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Rahl | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. GIVE WAR OR DATES
WWII | | 16b. SOCIAL SECURITY NO.
577-24-3478 | | 17. INFORMANT ADDRESS
Anna Butler- 228-Revere St.,
Harrisburg, Pa. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
1850 IMMEDIATE CAUSE (a) METASTATIC CARCINOMA PROSTATE ~ 4 YRS | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 31, 19 71, to Dec. 31, 19 83, that (I) (we) lost saw the deceased alive on Dec. 31, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Bernard J. Rogus | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1/1/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Bernard J. Rogus | | 22e. ADDRESS
50 W EDMONSTON Dr Rockville MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
1-3-1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Bt. Lincoln Crematory | | 23d. LOCATION
Brentwood | | 23e. NAME
Bn. Geo. Md. | | | |
| 24. FUNERAL HOME
NAME
Valley's F.H. Inc.
Mt. Rainier, Md. | | ADDRESS
111 84 | | DATE REC'D. BY REGISTRAR
JAN 6 1984 | | REGISTRAR'S SIGNATURE
John J. Lohr | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

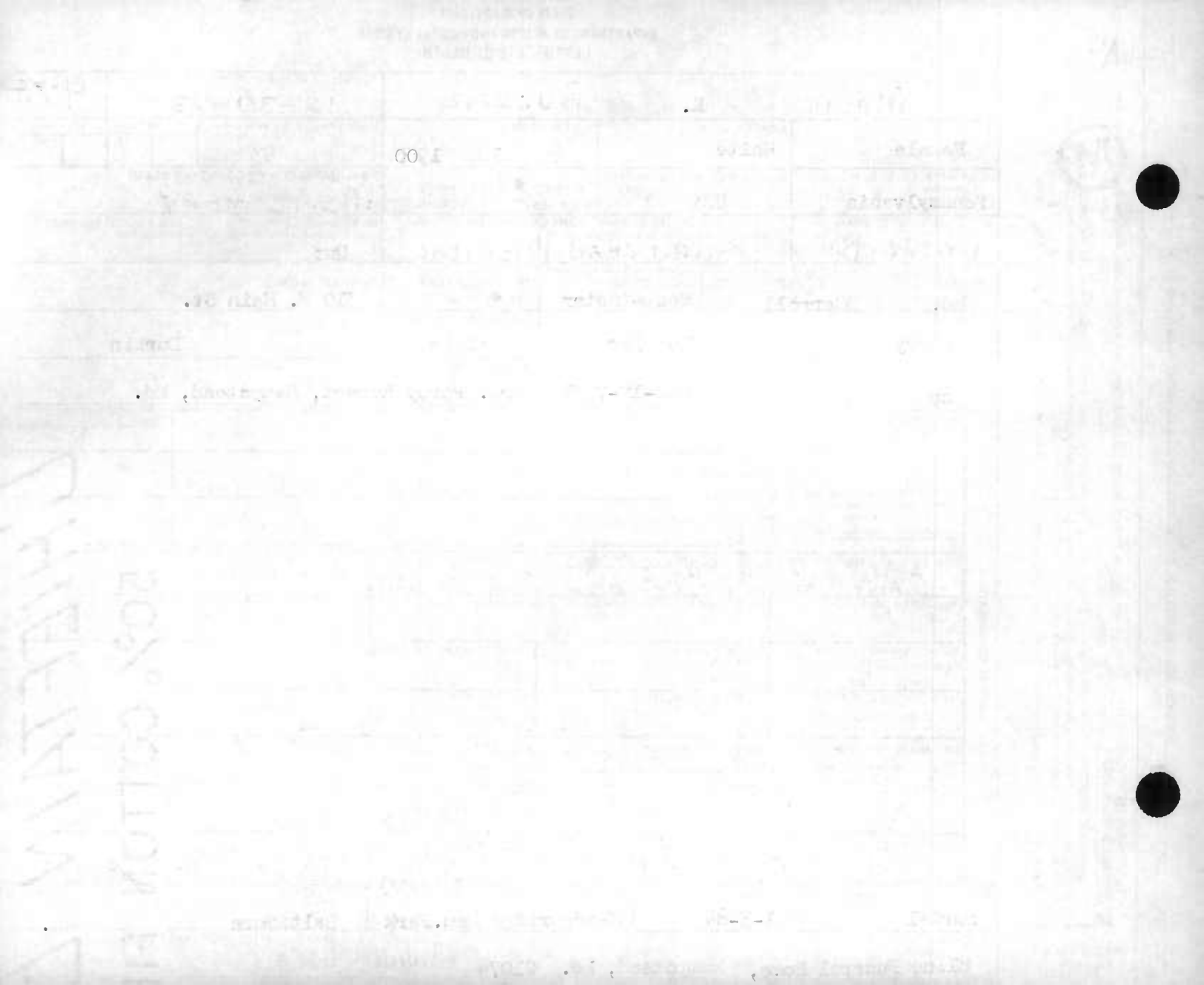
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
MARIE K. BURKER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12-30-83 | | | 2b. HOUR MIN.
4:50 A.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
8 10 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Hwf | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
Carroll | | 13c. CITY OR TOWN
Westminster | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
310 W. Main St. 21157 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Harry Beppler | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Elsie Durkin | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | | 16b. SOCIAL SECURITY NO.
218-12-7531 | | 17. INFORMANT ADDRESS
Mrs. Percy Rupert, Hampstead, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
4860
DUE TO, OR AS A CONSEQUENCE OF (b) Organism Undetermined
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a)
Arteriosclerotic Heart Disease with Congestive Failure
Arteriosclerotic Cerebrovascular Disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from October 19 83, to December 30, 19 83, that (1) (we) last saw the deceased alive on December 30, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
John F. Gustafson | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
December 30, 1983 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John F. Gustafson, M.D. | | | | 22e. ADDRESS
5480 Wisconsin Avenue Chevy Chase Md. 20815 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1-3-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
Eline Funeral Home, Hampstead, Md. 21074 | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1984 | | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John A. Ganiel | | | | | |

BP



20% COTTON
KELLY
100%

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) MARY DENIZA CALHOUN | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 11 1983 | | | 2b. HOUR
9:34 a | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 1 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WEST VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
WHEATON | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
12924 VALLEYWOOD DRIVE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM H. JUDY | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BARBARA D. KYLE | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | | 16b. SOCIAL SECURITY NO.
236-14-7172 | | 17. INFORMANT
ADDRESS
DOROTHY H. CALHOUN, 12924 VALLEYWOOD DRIVE, WHEATON, MD 20906 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 29 , 19 83 , to DECEMBER 11 , 19 83 , that (I) (we) lost saw the deceased alive on DECEMBER 11 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Michael D. Canty</i> DEGREE M.D. | | | | | 22c. DATE SIGNED
12 Dec 83 | | | 22d. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL D. CANTY, LT, MC, USNR | | | | | 22f. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Dec. 14, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Montgomery Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins
ADDRESS
500 University Blvd., W. Silver Spring, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1983 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Gwinn</i> | | |

MEDICAL CERTIFICATION

●

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST
JOSE CALVINO | | | | 12 22 83 | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
11 19 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Spain | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
COLLINGSWOOD NURSING CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CREWMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
TUG BOAT | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
NEMESIO | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARIA CRUZ | | 13e. STREET ADDRESS
13213 CARRIAGE COURT | | 20850 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
155-12-7967 | | 17. INFORMANT NAME AND ADDRESS
SON-IN-LAW NICHOLAS SUSZYSKI, 13213 CARRIAGE CT. ROCKVILLE, MD. 20850 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4254
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (c) Cardiomyopathy
DUE TO, OR AS A CONSEQUENCE OF (d) Intussusception | | | | 2 weeks 1 year 1 year | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from 12/21/83 to 12/22/83, that (I) (we) last saw the deceased alive on 12/21/83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (in (a)) (b)) (c)) (d)) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Thos G. Ward | | | | 22c. DATE SIGNED
12/22/83 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Thos G. Ward | | | | 22f. ADDRESS
1120 Conn Ave, N.W. #940 Washington, D.C. 20036 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (S)
CREMATION | | 23b. DATE
12/23/83 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
SUITLAND PG. MD. | |
| 24. FUNERAL DIRECTOR NAME
RICHARD RAPP, INC | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 28 1983 | | | |
| 25b. REGISTRAR'S SIGNATURE
Jan E. Carlin | | | | | | | |

BP

TO: THE SECRETARY OF THE ARMY
FROM: THE CHIEF OF STAFF
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report containing several paragraphs of text, possibly discussing military operations or administrative matters.]

100-100000-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP _____

DHMM - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
BEATRICE P. CATES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 17, 1983 | | | 2b. HOUR
6:30 A.M. | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
January 31 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2504 Randolph Road | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2504 Randolph Road 20902 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edgar J. Potter | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nellie Cunningham | | | 16. ADDRESS
13218 Superior St. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
216-28-5086 | | 17. INFORMANT
Son | | 17. ADDRESS
Lorance B. Cates, Jr. Rockville, Md. 20853 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hypertension
1552
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/17/83 to 12/17/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/17/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Allan B. Cohen, M.D. | | | | 22e. ADDRESS
13975 CONN. AVE. S-S Md 20906 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 20, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Montgomery Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Francis J. Collins
500 University Blvd., W. Silver Spring, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 23 1983 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|--|---|-------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) LOUIS (N.M.N.). Celentano | | | 2a. DATE OF DEATH MONTH DAY YEAR December 2, 1983 | | 2b. HOUR 3:20 PM | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR August 5, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Architect Retired | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov. | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Francisco Celentano | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Starace | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 114-03-7756 | |
| 17. INFORMANT Nancy D. Celentano-Wife | | 18. ADDRESS 603 Bonifant St., Silver Spring Md. | | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cordic Arhythmia
2733
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Gram Negative Sepsis
(c) Macroglobulinemia / Lymphoma | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hrs
3 days
6 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 12, 1978 , to 2 Dec 1983 , that (I) (we) lost saw the deceased alive on 2 Dec 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Eugene P. Libore | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 2 Dec 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. LIBORE | | 22e. ADDRESS 10400 Connecticut Ave. Hyattsville Md. 20785 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/5/83 | | 23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cemetery Chapel Point, Maryland | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR Archart Funeral Home, Inc. | | 24a. ADDRESS La Plata, Md. | | 25a. DATE REC'D. BY REGISTRAR DEC 07 1983 | | 25b. REGISTRAR'S SIGNATURE Se... | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do not delay.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FILED

12/1/53 St. Ignace Cemetery Chapel Point, Maryland
Catholic Funeral Home, Inc. - St. Ignace, Md.

12/1/53 St. Ignace Cemetery Chapel Point, Maryland
Catholic Funeral Home, Inc. - St. Ignace, Md.

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12/1/53 St. Ignace Cemetery Chapel Point, Maryland
Catholic Funeral Home, Inc. - St. Ignace, Md.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|-----------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Emma J. Centa. | | | 2a. DATE OF DEATH
MONTH DEC DAY 31 YEAR 1983 | | | 2b. HOUR
M | | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH JUNE DAY 26 YEAR 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
CANADA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
KENSINGTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
KENSINGTON GARDENS | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | | | 13b. COUNTY
PR GEO | | 13c. CITY OR TOWN
LANGLEY PARK | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
8116 14th AVE 20783 | |
| 14. FATHER'S NAME
FIRST RICHARD MIDDLE LAST WELLS | | | | 15. MOTHER'S MAIDEN NAME
FIRST CATHERINE MIDDLE LAST CASHIN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
579-05-5806 | | 17. INFORMANT
ADDRESS
SYLVIA CLEVERING - 525 BEALL AVE. ROCKVILLE | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

3109

IMMEDIATE CAUSE (a)

RECURRENT PULMONARY ASPIRATIONAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
MONTHS

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

CHRONIC ORGANIC BRAIN SYNDROME**YEARS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

TARDIVE DYSKINESIA

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 4 , 19 80 , to 12/31 , 19 83 , that (I) (we) lost
saw the deceased alive on 12/27 , 19 83 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Martin C. Shargel | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/31/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARTIN C. SHARGEL | | 22e. ADDRESS
3720 FARRAGUT AVE.
KENSINGTON, MD - 20895 | | | | | |

| | | | | | | | |
|---|--|----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial. | | 23b. DATE
JAN. 5, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate Of Heaven | | 23d. LOCATION
CITY OR TOWN Rockville, Montg. Co. Md. COUNTY STATE | |
| 24. FUNERAL DIRECTOR
Takoma Funeral Home. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 09 1984 | | | |
| 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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June 26 1907

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Case 1:12-cv-00002-UNA Document 1-1 Filed 01/24/13 Page 1 of 1

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502-76-452

2005-2006, 2007-2008, 2009-2010, 2011-2012, 2013-2014, 2015-2016, 2017-2018, 2019-2020, 2021-2022, 2023-2024, 2025-2026, 2027-2028, 2029-2030, 2031-2032, 2033-2034, 2035-2036, 2037-2038, 2039-2040, 2041-2042, 2043-2044, 2045-2046, 2047-2048, 2049-2050, 2051-2052, 2053-2054, 2055-2056, 2057-2058, 2059-2060, 2061-2062, 2063-2064, 2065-2066, 2067-2068, 2069-2070, 2071-2072, 2073-2074, 2075-2076, 2077-2078, 2079-2080, 2081-2082, 2083-2084, 2085-2086, 2087-2088, 2089-2090, 2091-2092, 2093-2094, 2095-2096, 2097-2098, 2099-2100, 2101-2102, 2103-2104, 2105-2106, 2107-2108, 2109-2110, 2111-2112, 2113-2114, 2115-2116, 2117-2118, 2119-2120, 2121-2122, 2123-2124, 2125-2126, 2127-2128, 2129-2130, 2131-2132, 2133-2134, 2135-2136, 2137-2138, 2139-2140, 2141-2142, 2143-2144, 2145-2146, 2147-2148, 2149-2150, 2151-2152, 2153-2154, 2155-2156, 2157-2158, 2159-2160, 2161-2162, 2163-2164, 2165-2166, 2167-2168, 2169-2170, 2171-2172, 2173-2174, 2175-2176, 2177-2178, 2179-2180, 2181-2182, 2183-2184, 2185-2186, 2187-2188, 2189-2190, 2191-2192, 2193-2194, 2195-2196, 2197-2198, 2199-2200, 2201-2202, 2203-2204, 2205-2206, 2207-2208, 2209-2210, 2211-2212, 2213-2214, 2215-2216, 2217-2218, 2219-2220, 2221-2222, 2223-2224, 2225-2226, 2227-2228, 2229-2230, 2231-2232, 2233-2234, 2235-2236, 2237-2238, 2239-2240, 2241-2242, 2243-2244, 2245-2246, 2247-2248, 2249-2250, 2251-2252, 2253-2254, 2255-2256, 2257-2258, 2259-2260, 2261-2262, 2263-2264, 2265-2266, 2267-2268, 2269-2270, 2271-2272, 2273-2274, 2275-2276, 2277-2278, 2279-2280, 2281-2282, 2283-2284, 2285-2286, 2287-2288, 2289-2290, 2291-2292, 2293-2294, 2295-2296, 2297-2298, 2299-2300, 2301-2302, 2303-2304, 2305-2306, 2307-2308, 2309-2310, 2311-2312, 2313-2314, 2315-2316, 2317-2318, 2319-2320, 2321-2322, 2323-2324, 2325-2326, 2327-2328, 2329-2330, 2331-2332, 2333-2334, 2335-2336, 2337-2338, 2339-2340, 2341-2342, 2343-2344, 2345-2346, 2347-2348, 2349-2350, 2351-2352, 2353-2354, 2355-2356, 2357-2358, 2359-2360, 2361-2362, 2363-2364, 2365-2366, 2367-2368, 2369-2370, 2371-2372, 2373-2374, 2375-2376, 2377-2378, 2379-2380, 2381-2382, 2383-2384, 2385-2386, 2387-2388, 2389-2390, 2391-2392, 2393-2394, 2395-2396, 2397-2398, 2399-2400, 2401-2402, 2403-2404, 2405-2406, 2407-2408, 2409-2410, 2411-2412, 2413-2414, 2415-2416, 2417-2418, 2419-2420, 2421-2422, 2423-2424, 2425-2426, 2427-2428, 2429-2430, 2431-2432, 2433-2434, 2435-2436, 2437-2438, 2439-2440, 2441-2442, 2443-2444, 2445-2446, 2447-2448, 2449-2450, 2451-2452, 2453-2454, 2455-2456, 2457-2458, 2459-2460, 2461-2462, 2463-2464, 2465-2466, 2467-2468, 2469-2470, 2471-2472, 2473-2474, 2475-2476, 2477-2478, 2479-2480, 2481-2482, 2483-2484, 2485-2486, 2487-2488, 2489-2490, 2491-2492, 2493-2494, 2495-2496, 2497-2498, 2499-2500, 2501-2502, 2503-2504, 2505-2506, 2507-2508, 2509-2510, 2511-2512, 2513-2514, 2515-2516, 2517-2518, 2519-2520, 2521-2522, 2523-2524, 2525-2526, 2527-2528, 2529-2530, 2531-2532, 2533-2534, 2535-2536, 2537-2538, 2539-2540, 2541-2542, 2543-2544, 2545-2546, 2547-2548, 2549-2550, 2551-2552, 2553-2554, 2555-2556, 2557-2558, 2559-2560, 2561-2562, 2563-2564, 2565-2566, 2567-2568, 2569-2570, 2571-2572, 2573-2574, 2575-2576, 2577-2578, 2579-2580, 2581-2582, 2583-2584, 2585-2586, 2587-2588, 2589-2590, 2591-2592, 2593-2594, 2595-2596, 2597-2598, 2599-2600, 2601-2602, 2603-2604, 2605-2606, 2607-2608, 2609-2610, 2611-2612, 2613-2614, 2615-2616, 2617-2618, 2619-2620, 2621-2622, 2623-2624, 2625-2626, 2627-2628, 2629-2630, 2631-2632, 2633-2634, 2635-2636, 2637-2638, 2639-2640, 2641-2642, 2643-2644, 2645-2646, 2647-2648, 2649-2650, 2651-2652, 2653-2654, 2655-2656, 2657-2658, 2659-2660, 2661-2662, 2663-2664, 2665-2666, 2667-2668, 2669-2670, 2671-2672, 2673-2674, 2675-2676, 2677-2678, 2679-2680, 2681-2682, 2683-2684, 2685-2686, 2687-2688, 2689-2690, 2691-2692, 2693-2694, 2695-2696, 2697-2698, 2699-2700, 2701-2702, 2703-2704, 2705-2706, 2707-2708, 2709-2710, 2711-2712, 2713-2714, 2715-2716, 2717-2718, 2719-2720, 2721-2722, 2723-2724, 2725-2726, 2727-2728, 2729-2730, 2731-2732, 2733-2734, 2735-2736, 2737-2738, 2739-2740, 2741-2742, 2743-2744, 2745-2746, 2747-2748, 27

2000-01-01 to 2000-01-01

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Mr. C.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "W" 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
20M 4/B2

1 FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

ARNHILD CHAMBERS

REG. NO.

| | | | | | | | | |
|---|---------------------|--|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Arnhild NMN Chambers</i> | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <i>Dec 13, 1983</i> | | | 2b. HOUR <i>7:50</i> | | |
| 3. SEX
<i>F</i> | 4. RACE
<i>W</i> | 5. DATE OF BIRTH
MONTH DAY YEAR <i>11/8/17</i> | 6. AGE (IN YEARS)
LAST BIRTHDAY <i>66</i> YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD
<i>Dec. 13, 1983</i> | 2d. HOUR <i>7:50</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>NORWAY</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery MD.</i> | | |
| 10. CITY OR TOWN OF DEATH
<i>Tok Park</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Wach. Advent. Hosp.</i> | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>PHYSICAL THERAPIST</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
<i>MD.</i> | | 13b. COUNTY
<i>Mont</i> | | 13c. CITY OR TOWN
<i>Bel Sp.</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>TERJUSSEN</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>SELMA</i> | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) <i>NO</i> | | | | |
| 17. INFORMANT
<i>RICHARD E. CHAMBERS</i> | | ADDRESS
<i>8803 PLYMOUTH ST 20901</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute myocardial inf.</i>
4029 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. }
(b) <i>Hypertension</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Yrs</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION
<i>None</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
<i>[Signature]</i> | | TITLE (SPECIFY)
<i>M.D. Dep</i> | | | | | DATE SIGNED
<i>Dec 14/83</i> | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <i>Burial</i> | | 23b. DATE
<i>Dec. 19, 1983</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Maryland Veterans Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Chesapeake MD</i> | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Takoma Funeral Home & Mortuary</i> | | ADDRESS
<i>250 Carroll St NW</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 19 1983</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |

10/20/2011

TESTING

10/20/2011

10/20/2011

10/20/2011

10/20/2011

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ELENA CHIARA | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/04/83 | | 2b. HOUR
11:55am | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YR
06 02 97 | |
| 6. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
ITALY | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
HOLY CROSS HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE D.C. | | 13b. CITY OR TOWN
WASHINGTON | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PIETRO diGIROLAMO | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CONCETTA deMICIS | | 13d. STREET ADDRESS
1884 COLUMBIA RD, WASH D.C. N.W. 20009 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) 577-58-0631 | | 17. INFORMANT
ADDRESS
DAUGHTER 3506 CALVEND LANE
FLORENCE L. BARNES KENSINGTON MD. 20895 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4275 Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 min | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 4 1983 to Dec 4 1983, that (I) (we) last saw the deceased alive on Dec 4 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
William J. Meggs | | | | 22c. DATE SIGNED
Dec 4 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WILLIAM J. MEGGS | | 22e. ADDRESS
HOLY CROSS HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
DEC. 7, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
ROCK CREEK CEMETERY | |
| 23d. LOCATION
(CITY OR TOWN)
WASHINGTON, D.C. | | 23e. COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1983 | |
| 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. | | | | 25b. REGISTRAR'S SIGNATURE
John J. Smith | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. A physician may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages read 2 should be filled with the cause of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



WASHINGTON COUNTY

XX

NEW KENNETH - NEW CROSS HOSPITAL

1988 COLUMBIA RD, WASH. D.C.

X

030-1-030

8 3 3 3 5 8 8

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Hilda Lefevre Chiles | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/14/83 | | 2b. HOUR
2:40 AM |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
FEB 23 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
W. Va. | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
— | | 13b. COUNTY
— | 13c. CITY OR TOWN
WASH. D.C. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
4717 ALBEMARLE ST. N.W. |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HARRY D. LEFEVRE | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
NELLIE LAMON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
577036648 | | 17. INFORMANT
ADDRESS
JOHN D. CHILES SAME # 13 | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) renal failure
0384
DUE TO, OR AS A CONSEQUENCE OF
(b) shock
DUE TO, OR AS A CONSEQUENCE OF
(c) gram negative septicemia | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c):
old cerebrovascular accident

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/13 1983, to 12/14 1983, that (we) lost saw the deceased alive above (I) (we) (did) (did not) view the body after death, and that in my (our) opinion death occurred on the date and hour and from the causes stated | | | |
| 22b. SIGNATURE
Sidney J. Malawer, M.D. | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
12/14/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SIDNEY J. MALAWER M.D. | | 22e. ADDRESS
10215 FERNWOOD RD. BETH. MD. | |

| | | | |
|--|--------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
DEC 17 1983 | 23c. NAME OF CEMETERY OR CREMATORY
MT. HEBRON CEM | 23d. LOCATION
CITY OR TOWN COUNTY STATE
WINCHESTER VA |
| 24. FUNERAL DIRECTOR
NAME
DEVAL FUNERAL HOME | | 25a. DATE REC'D. BY REGISTRAR
19 1983 | |
| 25b. REGISTRAR'S SIGNATURE
John J. Conner | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR Item #17 G588 2/6/84 CW

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
THOMAS W. CLARK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 25 83 | | | 2b. HOUR
954 P.M. | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 27, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY County, MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL ASSOCIATION | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Operator Grocery Store | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Virginia | | 13b. COUNTY
None | | 13c. CITY OR TOWN
Winchester | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John William Clark | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Martha Regina Neff | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | |
| 16b. SOCIAL SECURITY NO.
577 03 6547 | | 17. INFORMANT
12500 Neddle Drive
Thomas G. Clark Clarksburg, Md. 20871 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
4100
DUE TO, OR AS A CONSEQUENCE OF (b) DIABETES HYPOTENSION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) VISCERAL EPISODE AND CARDIOMYOPATHY
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from November 19, 83, to December 25, 83, that (I) (we) last saw the deceased alive on December 25, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Mark F. Weinstein MD | | | | DEGREE
MD | | 22c. DATE SIGNED
December 25, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARK F. WEINSTEIN MD | | | | 22e. ADDRESS
11125 Rockville Pike, Rockville MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 29, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Shenandoah Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Winchester, Virginia | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT A. PUMPHREY FUNERAL HOMES, PA. BETHESDA, MARYLAND | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1984 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | | | |

20K-CC-10M-11

CHIEF-11M



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
VESTA TANNER CLARK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 29 1983 | | | 2b. HOUR
P M
5:39 P | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
AUGUST 26 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
69 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GEORGIA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
DELAWARE | | 13b. COUNTY
NEW CASTLE | | 13c. CITY OR TOWN
CLAYMONT | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
28 NAAMANS TRAILER COURT 99499 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES TANNER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ADDIE COLE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
258-20-2694 | | 17. INFORMANT
ADDRESS
HARRY A. CLARK, 28 NAAMANS TRAILER PARK, | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **ADENOCARCINOMA**

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 1/2 YEARS

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 29, 1983 to DECEMBER 29, 1983 , that (I) (we) last saw the deceased alive on DECEMBER 29, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
J. E. WILSON, LCDR, MC, USN | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/30/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. E. WILSON, LCDR, MC, USN | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | |

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
Dec. 30, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Chambers Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rivdale P. G. MD. | |
| 24. FUNERAL DIRECTOR
NAME
W.W. Chambers Co. | | ADDRESS
8655 Georgia Av
Silver Spring, Md 20910 | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1984 | | 25b. REGISTRAR'S SIGNATURE
John J. Casper | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15/08/21

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 3 3 3 5 9 1

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Eleanor P Clements | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 30 83 | | 2b. HOUR
07:41 AM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
2 11 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Co. Government | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. 13b. COUNTY Montg. 13c. CITY OR TOWN Gaithersburg | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
17654 Amity Dr. 20877 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Walter Poole | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mabel Hungerford | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
220-409779 | | 17. INFORMANT
ADDRESS
Wm. Clements Gaithersburg Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
5688 IMMEDIATE CAUSE (a) Retroperitoneal hematoma and bleeding
DUE TO, OR AS A CONSEQUENCE OF
(b) of unknown etiology
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
cirrhosis, cholelithiasis | | | | | |
| 19a. DATE OF OPERATION
12/28/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Retroperitoneal Hematoma | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from Dec 29 , 19 83 , to Dec 30 , 19 83 , that (1) (we) lost
saw the deceased alive on Dec 29 30 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Robert H. Varney, MD | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/30/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert H. Varney | | 22e. ADDRESS
9915 Medical Center Drive, Rockville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
1/3/84 | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Montg. Md. | | |
| 24. FUNERAL DIRECTOR
NAME
W E Helt | | ADDRESS
Baltimore Md 20833 | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1984 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|---------|--|--|--|------|---|----------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | LAST | | |
| JOHN MARSHALL COFFEY | | December 16, 1983 | | | | 2:40A | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| Male | White | MONTH DAY YEAR | | 39 YRS. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| OKLA. | | U.S.A. | | | | Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Bethesda | | National Institutes of Health | | Attorney | | Self-employed | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. INSIDE CITY LIMITS? | | 13b. STREET ADDRESS | | 13c. CITY OR TOWN | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. STREET ADDRESS | |
| Virginia | | Arlington | | Arlington | | 1909 N. Woodley St., 22207 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| A. Langley | | Serena A. Winder | | Yes | | 448-44-8449 | |
| 17. INFORMANT | | ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Virginia M. Coffey (wife) | | 1909 N. Woodley St. Arlington, Va. 22207 | | CARDIAC FAILURE | | | |
| | | | | IMMEDIATE CAUSE (a) | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | | | (b) NO ANATOMIC CAUSE OF DEATH IDENTIFIED | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | | | (c) | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | | | |
| S/P CORONARY ARTERY BYPASS GRAFTS X3 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 12/15/83 | | Coronary artery disease | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN COUNTY STATE | |
| | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 7, 1983, to December 16, 1983, that (we) last saw the deceased alive on December 16, 1983, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| David J. Underhill | | | | 12/16/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. DATE REC'D. BY REGISTRAR | | 22g. REGISTRAR'S SIGNATURE | |
| David Underhill | | The Clinical Ctr., National Institutes of Health, Bethesda, MD 20205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 12/20/83 | | Woodland Cemetery | | Sand Springs, Oklahoma | |
| 24. FUNERAL DIRECTOR NAME | | 24a. ADDRESS | | 24b. DATE REC'D. BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | |
| MURPHY FUNERAL HOMES, INC. | | 4510 Wilson Blvd., Arlington, Virginia 22203 | | DEC 21 1983 | | Sam J. Connel | |

RECEIVED
DEC 21 1952

DATE

20% CO-10M



DEC 21 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
|---|---|--|----------------------|--|-----------------------------------|
| LILLIAN COHEN | | Dec. 6, 1983 | | 5:35 AM | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE | |
| Female | Caucasian | Aug. 28, 1921 | | 62 | |
| 7a BIRTHPLACE | 7b CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| New York | USA | | | Montgomery MD. | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Rockville | 5815 Edson Lane | | Housewife | | Home |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| Maryland | | Montgomery | Rockville | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 5815 Edson Lane 20852 |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| Adolph Bauman | | Elizabeth Fein | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT ADDRESS | |
| No | | 100 12 7944 | | Max Cohen Husband same as #13 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
<u>1629</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>metastatic lung cancer</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 hours</u>
<u>2 years</u> | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from
saw the deceased alive on <u>11/18/83</u> <u>4</u> 19 <u>83</u> to <u>12/6</u> 19 <u>83</u> , that (I) <u>last</u>
above, (I) <u>did</u> (did not) view the body after death. | | 22b. SIGNATURE
<u>J. S. Macdonald</u>
PHYSICIAN'S NAME (TYPE OR PRINT) | | 22c. DATE SIGNED
Dec. 6, 1983 | |
| 22d. ADDRESS
<u>5401 Western Ave., Washington, D.C. 20015</u> | | 22e. ADDRESS
<u>5401 Western Ave., Washington, D.C. 20015</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | Dec. 8, 1983 | | Beth El and Cedar Park | |
| 24. FUNERAL DIRECTOR'S NAME | | 24b. DATE REC'D. BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | |
| Eves-Pearson Funeral Homes
Falls Church, Va. 22046 | | DEC 12 1983 | | <u>John J. Conner</u> | |

BP

102

SECTION



REC-17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8 3 3 3 5 9 4 | | | |
|---|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Herbert COLE | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 29 83 | | | | 2b. HOUR
11 13 PM | | | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
8 11 92 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 | | 7. IF UNDER 1 YEAR MONTHS DAYS
YRS. | | 8. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NY | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bethesda HEALTH Ctr. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Executive Ret. | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Business | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
BETHESDA | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4977 Battery Lane 20814 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
SOLOMON PRICE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
PAULINE PRICE | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
None | | | | 16b. SOCIAL SECURITY NO.
063-03-6011 | | 17. INFORMANT ADDRESS
Mrs. Claire C. Hamula, Dir. Bethesda Md 20814 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4140 Ruptured Aortic Aneurysm
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate
years
years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
6116 Robinwood Bethesda 20817 | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | |
| 22a. SIGNATURE
Thomas J. Ward | | | | DEGREE
M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22e. DATE SIGNED
12/30/83 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
Thos G. WARD | | | | 22c. ADDRESS
6116 Robinwood Bethesda 20817 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | | | 23b. DATE
Dec. 30, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Chambers Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Riverdale P.G. City Maryland | | | |
| 24. FUNERAL DIRECTOR NAME
W.W. Chambers Co. | | | | ADDRESS
8655 Georgia Ave. S.S. Md | | | | 25. DATE REC'D BY REGISTRAR
JAN 5 1984 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | | | |

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|-------------------------|--|---|---|------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
RITA CHRISTINA COLLIER | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 8, 1983 | | 2b. HOUR
4:45 p.m. |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
APRIL 1, 1935 | | 6. AGE (IN YEARS LAST BIRTHDAY)
48 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE CLINICAL CENTER, NIH | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Admin. Ass't. | | | 12b. KIND OF BUSINESS OR INDUSTRY
CIA | | |
| 13a. STATE
VIRGINIA | | 13b. COUNTY
Fairfax | 13c. CITY OR TOWN
MCCLEAN | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles --- Delvecchio | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rita --- Basso | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
578-48-9748 | | 17. INFORMANT
MR. DAVID COLLIER (HUSBAND) | |
| 18a. ADDRESS
1531 FOREST VILLA LANE | | 18b. ADDRESS
1531 FOREST VILLA LANE | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Sepsis**

1539
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Bowel perforations**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Metastatic colonie carcinoma**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)

| | | | | | |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 17, 1983 , to DECEMBER 8, 1983 , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on December 8, 1983 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated
above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Ellen mellow | | DEGREE | | 22c. DATE SIGNED
12/9/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ELLEN MELLOW | | 22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH
CLINICAL CENTER, BETHESDA, MARYLAND 20205 | | | |

| | | | |
|---|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
12/12/83 | 23c. NAME OF CEMETERY OR CREMATORY
National Memorial Park | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church, Virginia |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc. | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1983 | |
| 24. ADDRESS
5130 Wisconsin Ave., NW, Washington, D.C. 20016 | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Washington, D.C.

Adm. Serv. Div.

Office of the Director

Charles

Belmont

--

Bureau

to

2550 Macomb Ave., N.W., Washington, D.C. 20035
Joseph G. ...
National Memorial ...
This Church, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMM - 16 50M 4/82
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|--|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) ELAZABETH J CONN | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-15-83 | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 02 09 92 | | 6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHYBURN Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Receptionist | | 12b. KIND OF BUSINESS OR INDUSTRY Hotel | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION): | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Bethesda | | 13e. STREET ADDRESS 4412 West Virginia Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Abner | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann McGee | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT (Sister) ADDRESS 4412 W. Virginia | | | |
| | | | | Grace P. Royal, Ave, Bethesda, MD | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ischemic encephalopathy
4140
DUE TO, OR AS A CONSEQUENCE OF
(b) pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) arteriosclerotic heart disease | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 wk.
9 days
10 yrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 116 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Jan. 19 80 to Dec 15 19 83 , that (I) (we) last saw the deceased alive on Dec 15 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE Marvin Wadler | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/15/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARVIN WADLER | | | | 22e. ADDRESS 8218 Wisconsin Av. Bethesda | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1983 Dec. 17, | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Maryland | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR DEC 19 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Smith | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **Part I** may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) John H. Coolick | | | | | 2a. DATE OF DEATH
MONTH Dec DAY 6 YEAR 1983 2b. HOUR 2:40 A. | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH Dec. DAY 28 YEAR 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 | | 7. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 HOURS 0 MIN. 0 | | | |
| 7a. BIRTHPLACE
(COUNTRY) Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Officer | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Army | | | |
| 13a. STATE
Md. 20906 | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST Ignatz MIDDLE Coolick LAST Coolick | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Mary MIDDLE Moore LAST House | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WWII | | | | | 16b. SOCIAL SECURITY NO.
579-44-2987 | | | | | 17. INFORMANT
Cora B. Coolick. Same as item 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4149 IMMEDIATE CAUSE (a) Cardio-Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF (c) and uremia
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
weeks 5 | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)
Probable Giant Cell Arteritis, Coronary Artery Disease, Atherosclerosis, Obstructive Pulmonary Disease, Alzheimer's | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/14/1978 to 12/6/83 , that (I) lost saw the deceased alive on 12/6/83 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Gustavo S. Belaval | | | | | | DEGREE
MD | | 22c. DATE SIGNED
6 Dec 83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gustavo S. Belaval | | | | | | 22e. ADDRESS
Leisure World Medical Center
Silver Spring, Maryland 20906 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | 23b. DATE
12/9/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cem. | | 23d. LOCATION
CITY OR TOWN Arlington COUNTY Virginia STATE | | | | |
| 24. FUNERAL DIRECTOR
NAME Joseph Gawler's Sons Inc.
ADDRESS 5130 Wisc. Ave., N.W. Wash., D. C. | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 12 1983 25b. REGISTRAR'S SIGNATURE John J. Smith | | | | | |



John Coolick Coolick

Male

White

Dec. 28 1904

78

xx

Penne.

U.S.A.

Montgomery

Olney

Montgomery General Hospital

Officer

U.S. Army

No. 20906

Montgomery Silver Building

15529 Prince Frederick Way

Female

Coolick

Male

Montgomery

Yes

WAI

300-11-2087

Corn N. Coolick. Same as item 13

x



and

12/19/1907

Wilmington National Cem.

Wilmington

Joseph Gaudier's Sons Inc.

110 N. 1st St. Wash., D.C.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ELIZABETH B. CRAWFORD | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-28-83 | | 2b. HOUR
4:45 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 22 1885 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
SCOTLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
WHEATON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
RANDOLPH HILLS NURSING HOME | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HARRY CARLSEN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY MONTGOMERY | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
579-12-6755 | | 17. INFORMANT
ADDRESS
MARY M. SPARKS DAUGHTER SAME AS 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory arrest
4292
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic cardiovascular disease
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate.
years. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
6/1 78 to 12/28 83 | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/28 83 to 12/28 83 , that (I) (we) last saw the deceased alive on 11/28 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 22a. SIGNATURE
James R. Coleman MD | | DEGREE
MD | | 22c. DATE SIGNED
12/28/83 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES R. COLEMAN | | 22d. ADDRESS
9241 COLUMBIA BLVD
SILVER SPRING, Md. 20910. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
DEC. 30, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
FORT LINCOLN CEMETERY BRENTWOOD PR. GEO. MD | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | ADDRESS
500 UNIVERSITY BLVD., W. SILVER SPRING, MD. | | 25. DATE OF REGISTRATION
JAN 6 1984 | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

20% CO₂ in air

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|---|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FLORENCE MEYER CRONON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 1, 1983 | | | 2b. HOUR
9 PM | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 5, 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
La Cross, Wisconsin | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Sandy Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Friends Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife Ret. | | 12b. KIND OF BUSINESS OR INDUSTRY
A Home | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sandy Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
Quaker Lane Apt 147 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Leo W. Meyer | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Louisa Ubler | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | 17. INFORMANT
ADDRESS
Madison, Wis. 53701 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary edema, acute
4292
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Congestive heart failure
(c) Arteriosclerotic cardiovascular disease | | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hr
1 wk
25 yr | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/18 , 19 90 , to 12/1 , 19 83 , that (I) was lost saw the deceased alive on 11/30 , 19 83 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
A. Dement Bonifant DEGREE MD | | | | | | 22c. DATE SIGNED
Dec. 2, 1983 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. DEMENT BONIFANT, M.D. | | | | | | 22e. ADDRESS
18111 Prince Phillip Dr., Olney, Md. | | | | |
| 23a. Method CREMATION, BURIAL, OR OTHER (SPECIFY)
Cremation | | | 23b. DATE
Dec. 7, 1983 | | 23c. NAME OF Crematory OR CREMATORY
Chambers Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Riverdale, P. G. Cty., Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
W. W. CHAMBERS Co. ADDRESS
8655 Ga. Ave. S. S. Md. 20910 | | | | | | 25. Signature BY REGISTRAR
DEC 7 1983 REGISTRAR'S SIGNATURE
John J. Lohr | | | | |

BP

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|---|---|---|---|---|---|---|---|---|----|----|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|--|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Kathleen M. Crowe | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 23, 1983 | | 2b. HOUR
3:40A.M |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
November 16, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ireland | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Potomac Valley Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Practical Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY
Physicians Office |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Rockville | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Mullally | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ann Concannon | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
081-24-8230 | | 17. INFORMANT
ADDRESS
Mr. Robert J. Crowe, Son,
7216 Blanchard Dr., Rockville MD. 20855 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4310 IMMEDIATE CAUSE (a) Respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) cerebral hemorrhage
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
instant
1 week
1 month | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Hypertension | | | | | |
| 19a. DATE OF OPERATION
12/14/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
19 | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 12/14/83 to 12/23/83 , that (1) (we) lost
saw the deceased alive on 12/14/83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Morton W. Shapiro | | DEGREE
M.D. | | 22c. DATE SIGNED
Dec. 23, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Morton W. Shapiro, M.D. | | 22e. ADDRESS
5225 Pooks Hill Road
Bethesda, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 27, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | |
| 23d. LOCATION
CITY OR TOWN
Hawthorne | | COUNTY
New York | | STATE | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes,
P.A., Rockville, Maryland | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Robert M. Crump | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-17-83 | | 2b. HOUR
4:00 A.M. | |
| 3. SEX
MALE | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
9-11-19 | 6. AGE (IN YEARS LAST BIRTHDAY)
64 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Continental Baking | |
| 13a. STATE
Maryland | | 13b. COUNTY
PR. GEO. | 13c. CITY OR TOWN
Laurel | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
6100 Goodman Road 20707 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George W. Crump | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma Mae Gibson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
216-05-5782 | | 17. INFORMANT
ADDRESS
Frances A. Crump Wife Same as 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia
4960
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic Obstructive Lung Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Hypotension | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/14 , 19 83 , to 12/17 , 19 83 , that (I) (we) lost
saw the deceased alive on 12/16 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Herman B Segal | | DEGREE
Dr. Frank Chavino | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/17/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Herman B Segal M.D. | | 22e. ADDRESS
11363 Georgia Ave Silver Spring Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 19, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Mont. Md. |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DEC 23 1983 John J. Connel | | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | | |

BP _____

1. The first part of the paper is devoted to a general discussion of the subject. It is shown that the problem is of great importance and that it has not been fully solved. The author then proceeds to a detailed examination of the various methods which have been proposed for its solution. It is found that each of these methods has its own merits and its own defects, and that no one of them is superior to the others in all respects. The author then proposes a new method, which he claims to be superior to all the others in every respect. This method is based on the principle of the least squares, and it is shown that it is capable of solving the problem in a much more efficient manner than any of the other methods.

2. The second part of the paper is devoted to a detailed examination of the various methods which have been proposed for its solution. It is found that each of these methods has its own merits and its own defects, and that no one of them is superior to the others in all respects. The author then proposes a new method, which he claims to be superior to all the others in every respect. This method is based on the principle of the least squares, and it is shown that it is capable of solving the problem in a much more efficient manner than any of the other methods.

3. The third part of the paper is devoted to a detailed examination of the various methods which have been proposed for its solution. It is found that each of these methods has its own merits and its own defects, and that no one of them is superior to the others in all respects. The author then proposes a new method, which he claims to be superior to all the others in every respect. This method is based on the principle of the least squares, and it is shown that it is capable of solving the problem in a much more efficient manner than any of the other methods.

4. The fourth part of the paper is devoted to a detailed examination of the various methods which have been proposed for its solution. It is found that each of these methods has its own merits and its own defects, and that no one of them is superior to the others in all respects. The author then proposes a new method, which he claims to be superior to all the others in every respect. This method is based on the principle of the least squares, and it is shown that it is capable of solving the problem in a much more efficient manner than any of the other methods.

5. The fifth part of the paper is devoted to a detailed examination of the various methods which have been proposed for its solution. It is found that each of these methods has its own merits and its own defects, and that no one of them is superior to the others in all respects. The author then proposes a new method, which he claims to be superior to all the others in every respect. This method is based on the principle of the least squares, and it is shown that it is capable of solving the problem in a much more efficient manner than any of the other methods.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 3 6 0 2
CERTIFICATE OF DEATH

| | | | | | |
|---|-------------------------|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Patricia Curtis | | | 2a. DATE OF DEATH
Month Day Year
12 31 83 | | 2b. HOUR
9:00P |
| 3. SEX
Female | 4. RACE
White | | 5. DATE OF BIRTH
12/21/83 | | 6. AGE (In years
lost birthday) YRS. MONTHS DAYS
-- -- 1 30 |
| 7a. BIRTHPLACE (State or foreign
country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) Holy Cross Hospital | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) None | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Maryland | | 13b. COUNTY Prince Geo. | 13c. CITY OR TOWN
Laurel | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET AND NUMBER 14915 Cherrywood Dr. | |
| 14. FATHER'S NAME First Middle Last
Terry Lee Curtis | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Carol Patricia Usilton | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT Father
Terry Lee Curtis, 14915 Cherrywood Dr. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) IMMATURITY
7651 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/31, 1983 , to 12/31, 1983 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
A. GEBRESELASSIE DEGREE | | | | 22c. DATE SIGNED
12/31/83 | |
| 22d. PHYSICIAN'S NAME (Type)
A. Gebreselassie | | | | 22e. ADDRESS
HOLY CROSS HOSPITAL | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 3, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | |
| 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Mont, Maryland | | 24. FUNERAL DIRECTOR
Deborah Davis Funeral Home, Inc.
2222 Wisconsin Ave., N. W., Washington, DC | | | |
| 25a. REC'D BY REGISTRAR
JAN 5 1984 | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | | | |

JAN 5 1984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Rose MARIE D'Ambrosio</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>12-8-83</i> | | 2b. HOUR
<i>245^A</i> M. |
| 3. SEX
<i>FEMALE</i> | 4. RACE
<i>WHITE</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>11 26-17</i> | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>66</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>WASHINGTON, D.C.</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>MONTGOMERY</i> MD. | | |
| 10. CITY OR TOWN OF DEATH
<i>SILVER SPRING</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>HOLY CROSS HOSPITAL</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>HOUSEWIFE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
<i>MARYLAND</i> | | | 13b. COUNTY
<i>MONTGOMERY</i> | 13c. CITY OR TOWN
<i>SILVER SPRING</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>NICHOLAS DiFILLIPO</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>10216 GEORGIA AVENUE 20902</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>578-10-8626</i> | 17. INFORMANT
<i>SON</i> ADDRESS <i>752 13TH ST., S.E.</i>
<i>RICHARD A. D'AMBROSIO, WASH., D.C. 20003</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
<i>4100</i> IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Myocardial Infarction</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Artery Disease</i> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>few hrs.</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<i>Previous Myocardial Infarction; Adult Onset Diabetes Mellitus</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/8</i> 19 <i>83</i> to <i>12/8</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>12/8</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Antonio G. Uy</i> | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>12/8/83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>ANTONIO G. UY MD</i> | | 22e. ADDRESS
<i>831 Univ Blvd #25 Silver Spring MD 20903</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>BURIAL</i> | | 23b. DATE
<i>12/10/83</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>GATE OF HEAVEN</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>SILVER SPRING MONT MD.</i> |
| 24. FUNERAL DIRECTOR
NAME
<i>FRANCIS J. COLLINS</i>
ADDRESS
<i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i> | | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 13 1983</i> | | |
| | | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Ganiel</i> | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
William M. Darling | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 1 '83 | | | 2b. HOUR
30 P.M. | | |
| 3. SEX
Male | 4. RACE
Cauc. | 5. DATE OF BIRTH
MONTH DAY YEAR
12 6 94 | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | 12. OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | | 13. KIND OF BUSINESS OR INDUSTRY
G.P.O. | |
| 13a. STATE
Md. | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Silver Spring | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William M. Darling | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Smith | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) N/A | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) N/A | | | 17. INFORMANT
ADDRESS
Louise A. Darling-wife-(same as 13e) | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>BACTEREMIA</u>
4029
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|--|--|---|

| | | | |
|---|--|--|---|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>HYPERTENSIVE AND ARTERIO SCLEROTIC HEART DISEASE, PNEUMONIA</u> | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 1</u> , 19 <u>83</u> , to <u>Dec 1</u> , 19 <u>83</u> , that (I) (we) lost
saw the deceased alive on <u>Dec 1</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Robert L. Krichmar</u> | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
<u>DEC 1 1983</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>ROBERT L. KRICHMAR MD</u> | 22e. ADDRESS
<u>7733 ALASKA DRIVE NW
WASHINGTON D.C. 20012</u> | | |

| | | | |
|--|---------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Dec. 5, 1983 | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pr. Georges, Md. |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi Funeral Home | | 25a. DATE REC'D. BY REGISTRAR
25b. REGISTRAR'S SIGNATURE
<u>John J. [Signature]</u>
DEC 5 - 1983 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Frank A. Davis | | | 2a. DATE OF DEATH
MONTH 12 DAY 24 YEAR 83 | | 2b. HOUR
2:55 A.M. |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH Sep. DAY 16 YEAR 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | IF UNDER 1 YEAR
MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Foreign Service | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't | |
| 13a. STATE
Maryland | | | 13b. CITY OR TOWN
Bethesda | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST Charles MIDDLE M. LAST Davis | | | 15. MOTHER'S MAIDEN NAME
FIRST Lillian MIDDLE M. LAST unknown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO.
286 09 3941 | | 17. INFORMANT
ADDRESS Maryland 20814
Sally D. Hyatt, 4853 Cordell Av., Bethesda. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute irreversible Renal Failure
4039
DUE TO, OR AS A CONSEQUENCE OF
(b) Negative sclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | |
| 19a. DATE OF OPERATION
11-8-83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Cervical Spine Fusion | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR 19
P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-31 , 19 83 , to Dec 23 , 19 85 , that (I) (we) lost
saw the deceased alive on Dec 23 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Robert T. Thibadeau DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT T. THIBADEAU | | | 22d. ADDRESS
Kochville, Md 20852 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
12/24/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | |
| 23d. LOCATION
CITY OR TOWN Alexandria COUNTY STATE Virginia | | | | | |
| 24. FUNERAL DIRECTOR
NAME Robert A. Pumphrey's Funeral Homes
P.A. Bethesda, Maryland | | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1983 | | 25b. REGISTRAR'S SIGNATURE
John E. Curren |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified after death.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|------------------|--|---|---|--------------------------------|---|--|--|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARY HELEN DAWES | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 26 1983 | | 2b. HOUR A | | | |
| 1. SEX F | 4. RACE N | 5. DATE OF BIRTH
MONTH DAY YEAR 12 10 07 | 6. AGE (IN YEARS)
LAST BIRTHDAY 76 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD 12 26 1983 | | 2d. HOUR 9:30 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1220 EAST WEST HIGHWAY | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE NEW YORK | | 13b. CITY OR TOWN BROOKLYN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2224 E. 15th St | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Henry Thurber | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Pearl Moore | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. Not Stated | | 17. INFORMANT AD 1220 E. W. Highway
Emma Thurber Williams, Sister, S. S. Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>
DUE TO, OR AS A CONSEQUENCE OF
ARTEROSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ACUTE
YKS | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
HYPERTENSIVE CARDIOVASCULAR DISEASE | | | | | | | | | | | |
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR AM P.M. 12 26 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) DIED IN SLEEP | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE 150 East West Silver Spring Montgomery Md | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Ernest Jarvis | | TITLE (SPECIFY) MD | | MEDICAL EXAMINER | | DATE SIGNED 12/26/83 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ernest Jarvis | | ADDRESS 1432 You St., N. W. | | 75a. DATE REC'D. BY REGISTRAR JAN 5 1984 | | 75b. REGISTRAR'S SIGNATURE John J. Lohr | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL CREMATION | | 23b. DATE 27 Dec 83 | | 23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE Washington, D. C. | | | | | |
| 24. FUNERAL DIRECTOR
NAME W. Ernest Jarvis Co., Inc. | | ADDRESS 1432 You St., N. W. | | 75a. DATE REC'D. BY REGISTRAR JAN 5 1984 | | 75b. REGISTRAR'S SIGNATURE John J. Lohr | | | | | |

Honorable

Henry Thirder

Not stated

1230 E. W. Highway
Mrs Thirder Williams, Sister, S. S. Md.

Washington, D. C.

W. Ernest Jarvis Co., Inc., Washington, D.C.
1932 E. W. W.
S. S. Jarvis, Inc's Secretary

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner will be notified and a medical certification will be required.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | | | |
|--|--|---|--|--|---|---|--|-----------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) Elmon Marcellus Day Jr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 05 83 | | | |
| 3. SEX MALE | | | | | 7b. HOUR 8:20 PM | | | |
| 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 7 4 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery, CO MD. | | |
| 10. CITY OR TOWN OF DEATH Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DRYWALL MECH. | | 12b. KIND OF BUSINESS OR INDUSTRY BUILDING | | |
| 13a. STATE MARYLAND | | 13b. COUNTY HOWARD | | 13c. CITY OR TOWN DAYTON | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 13e. STREET ADDRESS 4850 GREENBRIDGE RD. 21036 | | 14. FATHER'S NAME FIRST MIDDLE LAST ELMON MARCELLUS DAY, SR. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BEULAH JOHNSON | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16b. SOCIAL SECURITY NO. WW LL 213/26/9362 | | 17. INFORMANT MS. BETTY J. DAY | | ADDRESS 4850 GREENBRIDGE RD. DAYTON, MARYLAND 21036 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | |
| PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) PROGRESSIVE INTESTINAL PNEUMONITIS | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) STAGE IV B HODGKINS DISEASE | | DUE TO, OR AS A CONSEQUENCE OF | | | | |
| (c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: LUNG ABSCESS | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from August 12/5 , 19 82 , to 12/5 , 19 83 , that (1) (we) last saw the deceased alive on 12/5 , 19 83 , and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE | | ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/6/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature] | | 22e. ADDRESS 5540 TEN OAKS RD. CLARKSVILLE, MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12/9/83 | | 23c. NAME OF CEMETERY OR CREMATORY PROVIDENCE CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE GLENELG HOWARD MD | | |
| 24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME | | P.O. BOX 268 ELLICOTT CITY, MD 21043 | | 25a. DATE REC'D. BY REGISTRAR DEC 8 1983 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

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Montgomery

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Montgomery

Montgomery General Hospital

Olney

12 05 33 3:20 PM

Day Jr.

Montgomery

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Olney

12 05 33 3:20 PM

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12/13/19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be performed.

BH

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ERNEST ALTER DEEMS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 21, 1983 | | 2b. HOUR
A M
10:45 |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
DEC 27, 1928 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
M.D. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA, | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE CLINICAL CENTER, NIH | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DISABLED | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MARYLAND | 13b. COUNTY
BALTO | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
1015 CHERLYN RD 21221 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
VNK | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
VNK | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
VNK | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-24-9397 | | 17. INFORMANT
ADDRESS
MRS. MARY DEEMS (WIFE) SAME AS ABOVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
1940 IMMEDIATE CAUSE (a) RESPIRATORY ARREST, PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) LOWER GASTROINTESTINAL BLEED
DUE TO, OR AS A CONSEQUENCE OF
(c) METASTATIC ADRENAL CARCINOMA
7 YEARS | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 10, 1983 , to DECEMBER 21, 1983 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 21, 1983 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Richard V. Clark MD | | DEGREE
MD | | 22c. DATE SIGNED
12-21-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard V. Clark MD | | 22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH
CLINICAL CENTER, BETHESDA, MARYLAND 20205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL
Removal | 23b. DATE
12-22-83 | 23c. NAME OF CEMETERY OR CREMATORY
HOLY REDEEMER
Connelly Sons F/H | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
NAME
Marshall's Funeral Home | | ADDRESS
4217 9th St. N.W., Washington, D.C. 20011 | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1983 | |
| | | 25b. REGISTRAR'S SIGNATURE | | | |

BP

March 11 - 1941



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DHMH - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

33609

| | | | | | | | | | | |
|--|--|---|--|---|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Jimmie P Defelippo | | | 2a. DATE OF DEATH MONTH DAY YEAR
12-9-83 | | | 2b. HOUR
10:10 AM | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 16 26 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mississippi | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Urban Renewal Specialist | | 12b. KIND OF BUSINESS OR INDUSTRY
HUD | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10009 Dallas Avenue 20901 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John A. Pringle | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lutifay Walden | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | |
| 16b. SOCIAL SECURITY NO.
426-14-1505 | | | 17. INFORMANT
Joseph I. DeFelippo Husband Same as 13 | | | | | | | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Liver Failure
5728
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|--|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on **12/8/83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.

| | | | | | | | |
|---|--|--|--|--|--|------------------------------------|--|
| 22b. SIGNATURE
David B. Dyer, M.D. | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/9/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
David B. Dyer, M.D. | | 22e. ADDRESS
12006 Viers Mill Road Wheaton, Md | | | | | |

| | | | | | | | |
|--|--|-----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 13, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Virginia | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1983 | | | |
| 500 University Blvd., W. Silver Spring, Md. | | | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | |

Handwritten header text, possibly a date or page number.

Handwritten text at the top of the page, possibly a title or address.

Main body of handwritten text, appearing to be a letter or document.

Continuation of handwritten text, possibly a list or detailed notes.

Handwritten text at the bottom of the page, possibly a signature or footer.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

33610

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Lillian | | FIRST MIDDLE LAST
DEPAOLO | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-2-83 | | 2b. HOUR
3:45 PM | |
| 3. SEX
FEMALE | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 15, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
Virginia | | 13b. COUNTY
Fairfax | | 13c. CITY OR TOWN
Fairfax | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS
9129 Maywood Lane | | 13f. STREET ADDRESS
99999 | | 13g. STREET ADDRESS
9129 Maywood Lane | | 13h. STREET ADDRESS
99999 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dominick Crescenzo | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rosemary (Unknown) | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
163-03-1704 | |
| 16c. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16d. SOCIAL SECURITY NO.
163-03-1704 | | 17. INFORMANT (daughter) ADDRESS
Camille Szymczak Same as 13 | | 17. INFORMANT (daughter) ADDRESS
Camille Szymczak Same as 13 | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
5560 IMMEDIATE CAUSE (a) Gastrointestinal Bleeding | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Renal Failure | | | |
| Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last. | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Ulcerative Colitis | | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION
11/27/83; 11/29/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Gastrointestinal Hemorrhage | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from November 27, 1983, to December 2, 1983, that (b) (we) lost
saw the deceased alive on December 2, 1983, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated
above (d) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert H. Varney, MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/2/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert H. Varney | | 22e. ADDRESS
4715 Medical Center Drive, Rockville, Md. | | | | | |

| | | | | | | | |
|--|--|----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
Dec. 5, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | |
| 24. FUNERAL DIRECTOR
NAME
David L. Sauers Funeral Home, Falls Church, VA | | 24b. ADDRESS
Falls Church, VA | | 25a. DATE REC'D. BY REGISTRAR
DEC 12 1983 | | 25b. REGISTRAR'S SIGNATURE
John A. Davis | |



2026 CO11041

WALLA WALLA



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 33611 | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
Jean Diamond | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 7 83 | | | | 2b. HOUR
1124 P.M. | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
Dec. 19, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7b. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Poland | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6121 Montrose Road 20832 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Joseph Kramer | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Beckie Unknown | | | | ADDRESS
Silver Spring, Maryland | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
064 20 3249 | | 17. INFORMANT
Arnold Diamond-1105 Caddington Avenue. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>0389</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 day</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>Atherosclerotic Cardiovascular Disease</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
— | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. — 19 — | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)
— | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK
— | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
— | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
— | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 7</u> 19 <u>83</u> , to <u>Dec 7</u> 19 <u>83</u> , that I (we) lost saw the deceased alive on <u>Dec 7</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Raymond Bass</u> | | | | DEGREE <u>MD</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/8/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAYMOND BASS | | | | 22e. ADDRESS
3929 Fernside Dr Wheaton 20906 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Dec. 11 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Beth Moses Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Pinelawn, New York | | | |
| 24. FUNERAL DIRECTOR NAME
Ives-Pearson F. H. Arlington, Va. 22201 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 11 1983 | | | | | |
| | | | | | | REGISTRAR'S SIGNATURE
<u>John J. Connelley</u> | | | | | |

1958

RECEIVED

Mr. [illegible]
[illegible]
[illegible]

Dear Sir:

I am writing to you regarding [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

CHIEF

20%

1958

PLEASED
DR J. TOGERS

BY MEDICAL EXAMINER -

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

33612

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARTY B DIAMOND | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/08/83 | | 2b. HOUR
6:41pm |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH MONTH DAY YEAR
05 02 28 | | 6. AGE (IN YEARS LAST BIRTHDAY)
55 | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK AND KIND OF WORKING HOURS)
INSURANCE AGENT | 12b. KIND OF BUSINESS OR INDUSTRY
INSURANCE | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | 13b. CITY OR TOWN
SILVER SPR. | | 13c. STREET ADDRESS / ZIP CODE
1303 XAVERIA DRIVE 20903 |
| 14. FATHER'S NAME FIRST MIDDLE LAST
HERMAN DIAMOND | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
CELIA MERKEL | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
5/9-30-0717 | | 17. INFORMANT ADDRESS
Larry Alpert; 1107 Dunoon Road; SSpg, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8HR |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/8 , 19 83 , to 12/8 , 19 83 , that (I) (we) lost saw the deceased alive on 12/8 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Barry Shapiro | | DEGREE | | 22c. DATE SIGNED
12/8/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARRY SHAPIRO, M.D. | | 22e. ADDRESS
1500 Forest Glen Road: Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
12-9-1983 | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Garden | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Falls Church, Virginia | |
| 24. FUNERAL DIRECTOR NAME
Danzansky-Goldberg Chapels; | | ADDRESS
1170 Rockville Pike | | 25a. DATE REC'D BY REGISTRAR
DEC 13 1983 | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, go to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



12/28/03 6:41pm
MONTGOMERY COUNTY
INSURANCE AGENT
1303 XAVIER DRIVE
MONTGOMERY SILVER SPRING
SILVER SPRING
HOLY CROSS HOSPITAL
U.S.
WHITE
05 02 28
05 02 28
LIAMCHIO
12/28/03
6:41pm

RECEIVED
JAN 2 2004
MONTGOMERY COUNTY
INSURANCE AGENT
1303 XAVIER DRIVE
MONTGOMERY SILVER SPRING
SILVER SPRING
HOLY CROSS HOSPITAL
U.S.
WHITE
05 02 28
05 02 28
LIAMCHIO
12/28/03
6:41pm

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 1B show any injury, other traumatic event, (non-medical) event, must be filled out.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

33613

| | | | | |
|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ALBERT MERRITT Dietterich | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 20 83 | | 2b. HOUR
12:30 ^{PM} |
| 3. SEX
Male | 4. RACE
Cauc. | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 24, 1899 | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD | |
| 10. CITY OR TOWN OF DEATH
GAITHERSBURG | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HERMAN WILSON HEALTH CARE CTR | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Minister | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | 13b. COUNTY
Mont. | 13c. CITY OR TOWN
Gaithersburg | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ralph P. Dietterich | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Louise A. Owen | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
484-46-4722 | 17. INFORMANT
ADDRESS
401 Russell Ave.
Helen H. Dietterich Gaithersburg, Md. 20877 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma of the Pancreas
1579
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
13 mo. |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Diabetes mellitus, Recurrent urinary tract infection | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>
AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 19, 74, to Dec 20, 1983, that (I) (we) last saw the deceased alive on Dec 16, 1983, and that in (my) (our) opinion death occurred on the date and hour, and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
James R. Moore Jr. MD | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
12-30-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James R. Moore Jr. MD | 22e. ADDRESS
207 Brookes Ave Gaithersburg Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | 23b. DATE
12-20-1983 | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Gartner-Sandison Funeral Home
316 E. Diamond Ave. Gaithersburg, Md. 20877 | 25a. DATE REC'D. BY REGISTRAR
DEC 27 1983 | | 25b. REGISTRAR'S SIGNATURE
J. C. ... | |

Washington, D.C.

noit'ses

emol. Lignum' nonibne' tentat'

FILED IN DICTIONARY, Vol. 1, 1st Edition, 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

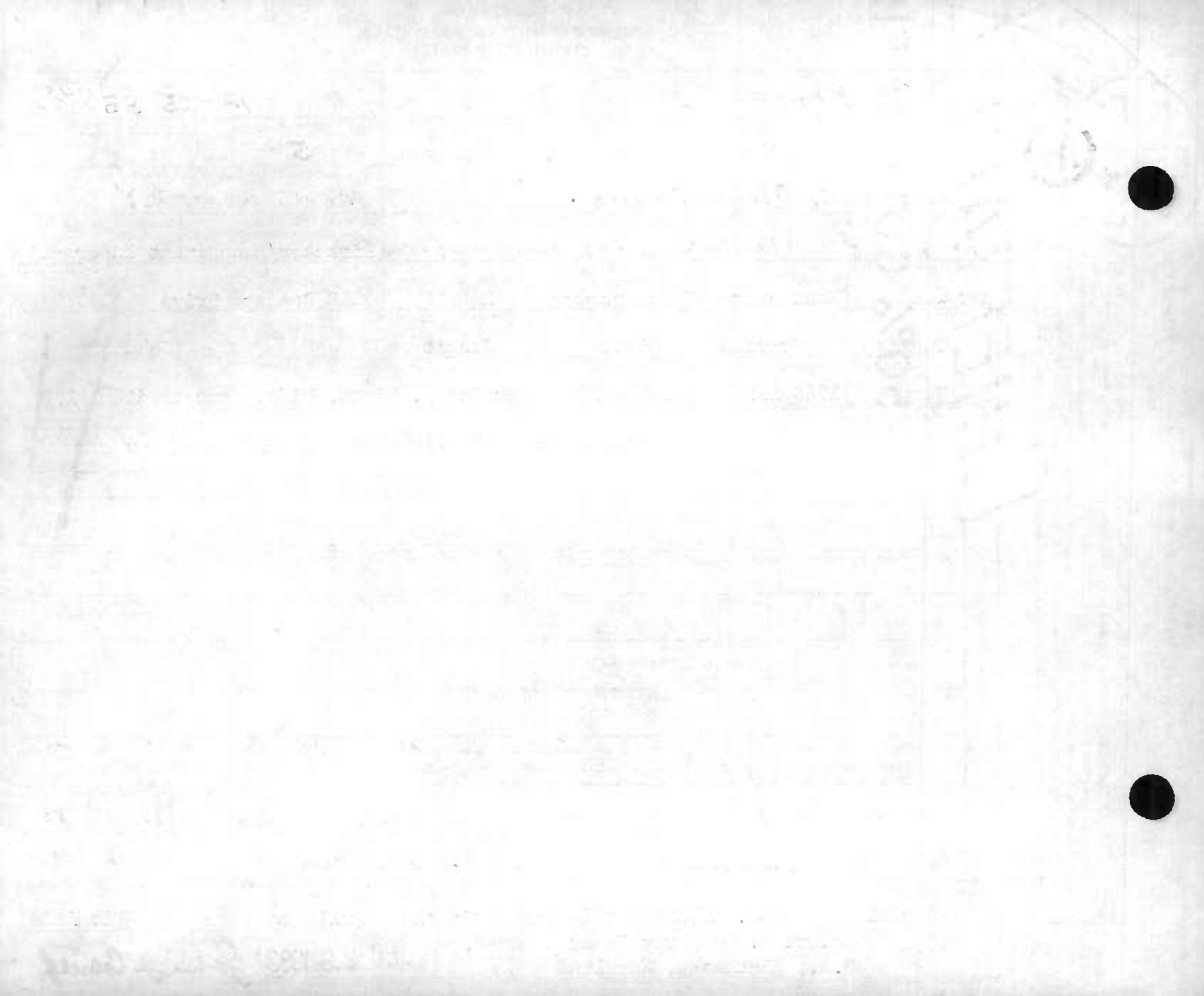
1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) BRUCE L. DIETZ | | | 2a. DATE OF DEATH
MONTH DAY YEAR 12-25-83 2b. HOUR 6:45 AM | | |
| 3. SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR 2-16-30 | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CALIFORNIA | 7b. CITIZEN OF WHAT COUNTRY? United States | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Collingswood Nursing Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Director/Management Information Systems | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Gaithersburg | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Grayton Dietz | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jessie Johnson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1948-1976 | 17. INFORMANT
ADDRESS
Bernice E. Dietz, Wife, Same as item #13 | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) GLIOBLASTOMA MULTIFORME
1919
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
14 MONTHS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from OCT 1982 to Dec 25 1983 , that (I) (we) lost
saw the deceased alive on Nov 9 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
William H. Silverman MD | | | | 22c. DATE SIGNED
12-25-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WILLIAM H. SILVERMAN | | | | 22e. ADDRESS
6111 EXECUTIVE BLVD, ROCKVILLE, MD. 20852 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 29, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Virginia | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | | |
| 25a. DATE REC'D. BY REGISTRAR
DEC 29 1983 | | | | 25b. REGISTRAR'S SIGNATURE
John J. Canfield | |

BP



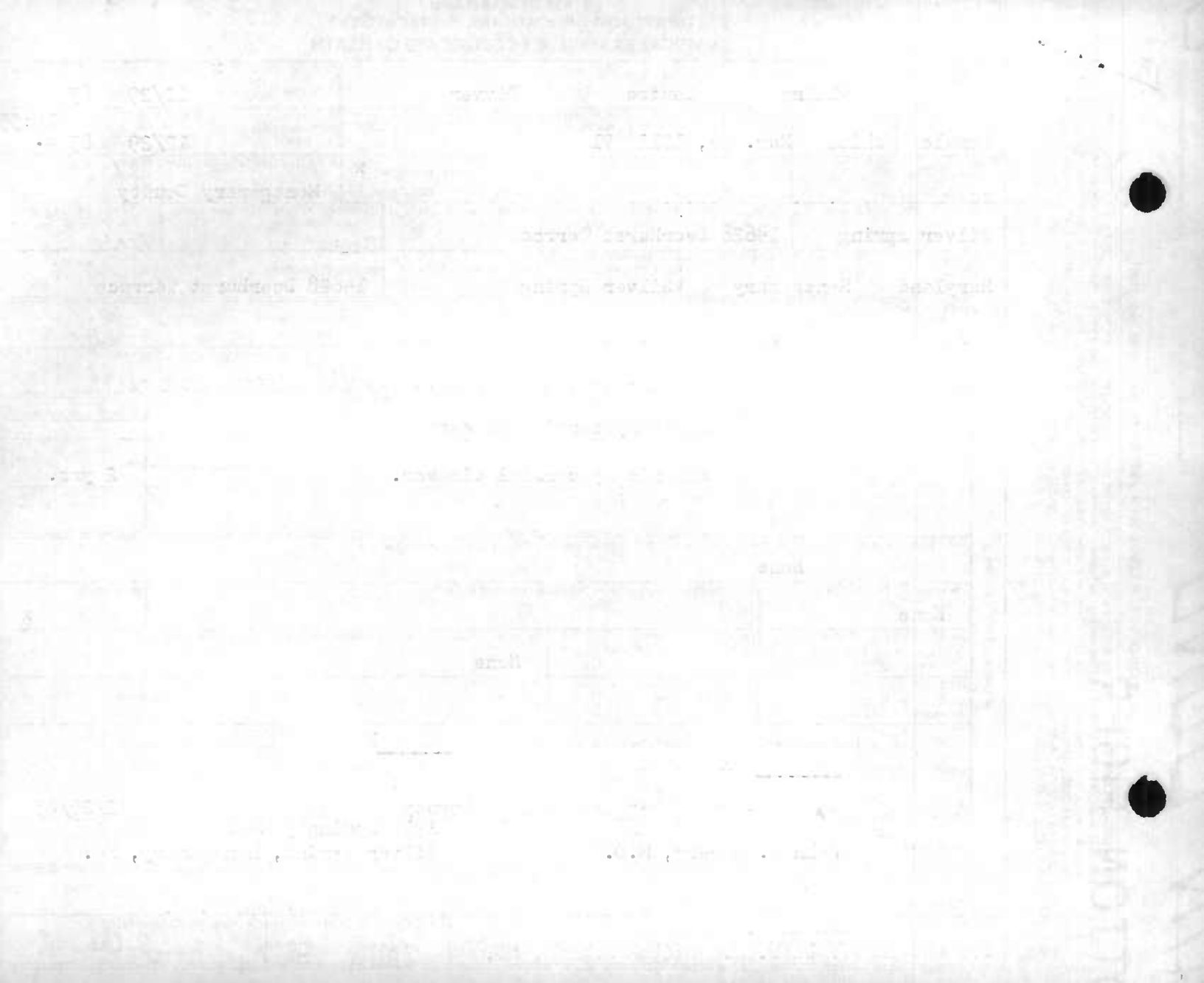
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|-------------------------------------|--|---|--|---|--|---|--|---|--|---|--|
| 1- STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Thelma | | MIDDLE
Louise | | LAST
Divver | | 2a. DATE KNOWN OF DEATH
ESTIMATED
<input checked="" type="checkbox"/> MONTH DAY YEAR
12/29 19 83 | | 2b. HOUR
M
10:55 | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Mar. 26, 1912 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
71 YRS. | | IF UNDER 1 YR.
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12/29 19 83 | | 2d. HOUR
A. M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D. C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
14628 Deerhurst Terrace | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Agriculture | |
| 13a. STATE
Maryland | | | | 13b. CITY OR TOWN
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
14628 Deerhurst Terrace 20906 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James E. Divver | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nellie Fanning | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
216-44-4502 | | 17. INFORMANT
Helen D. Divver Sister Same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u>
4291
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) <u>chronic myocardial disease.</u>
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 yrs. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
None | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John S. Rogers</i> | | | | TITLE (SPECIFY)
Deputy | | | | MEDICAL EXAMINER
1919 Seminary Road | | | | DATE SIGNED
12/29/83 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
John S. Rogers, M.D. | | | | ADDRESS
Silver Spring, Montgomery, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Dec. 31 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D. C. | | | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins | | | | ADDRESS
500 UNIVERSITY BLVD., W. SILVER SPRING, MD. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 6 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Conner</i> | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|-------------------------|--|---|--|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Bobby Junior Dodson | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED 12 19 83 | | 2b. HOUR
2:02pm | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR 10 31 1939 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 44 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
12 19 83 19 2:02pm | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park Md | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
washington Adventist Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Fence Company-Manufacture | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
PG | | 13c. CITY OR TOWN
Lewisdale Md | | 13d. INSIDE CITY LIMITS?
NO | | 13e. STREET ADDRESS
2411 Chapman Raod 20783 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Luther Dodson | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Matilda Nichols | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
231-38-7590 | | 17. INFORMANT ADDRESS
Evelyn Dodson-Same as items #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
4291 Acute myocardial Dis.
IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
None | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
John S. Rogers | | | | TITLE (SPECIFY)
MD. Dep. | | | | DATE SIGNED
Dec 19/1983 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) John S. Rogers | | | | ADDRESS 1919 Seminary Rd., Silver Spring | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/21/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood, P.G., Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Takoma Funeral Home | | | | | | ADDRESS
254 Carroll St. N.W. | | 25a. DATE REC'D. BY REGISTRAR
DEC 21 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Gault | |

Virginia

U.S.

Henry Company - Manufacturers

20733

Michigan

Michigan

Dobson

Dobson

231-32-7500 Twelve Ladies-James as items 113

1919 Seminary Rd., Silver Spring, Maryland.

John A. Dobson

Prentwood, P.O., Md.

12721/3 W. Lincoln

Capital

DEC 21 1933

National Funeral Home - Washington, D.C.

RJ

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|--|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | 7:00A M | |
| ANNA (NMN) DOMARUK | | December 6, 1983 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Female | White | MONTH DAY YEAR | 65 | IF UNDER 24 HRS. | |
| | | July 11, 1918 | | MONTHS DAYS | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| HUNGRAY | USA | | Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Bethesda | 4520 Windsor Lane | | retired | | -- |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| Maryland | | Montgomery | Bethesda | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 4520 Windsor Lane 20814 |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| JANOS - GACS | | ANNA - TOPH | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO NO | | 577-60-9186 | | Mr. Peter Domaruk (same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Bowel obstruction, secondary to peritoneal carcinomatosis | | | | | |
| 1519 DUE TO, OR AS A CONSEQUENCE OF (b) Gastric carcinoma | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 22, 1983, to December 6, 1983, that (we) lost
saw the deceased alive on November 5, 1983, and that in (we) (our) opinion death occurred on the date and hour and from the causes stated
above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| | | | | 6 DEC 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| DAVID M. HYAMS, M.D. | | National Institutes of Health, 9000 Rockville Pike, Bethesda, Maryland 20205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| Removal | 12-7-83 | Tyson Wheeler Funeral Home | Rockville, Md. | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS | | DEC 14 1983 | | | |
| Marshall's Funeral Home | | | | | |
| 4217 9th St N.W.: Washington, D.C. | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

A2N

2041

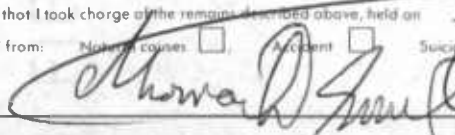

ACN 1-173

20%

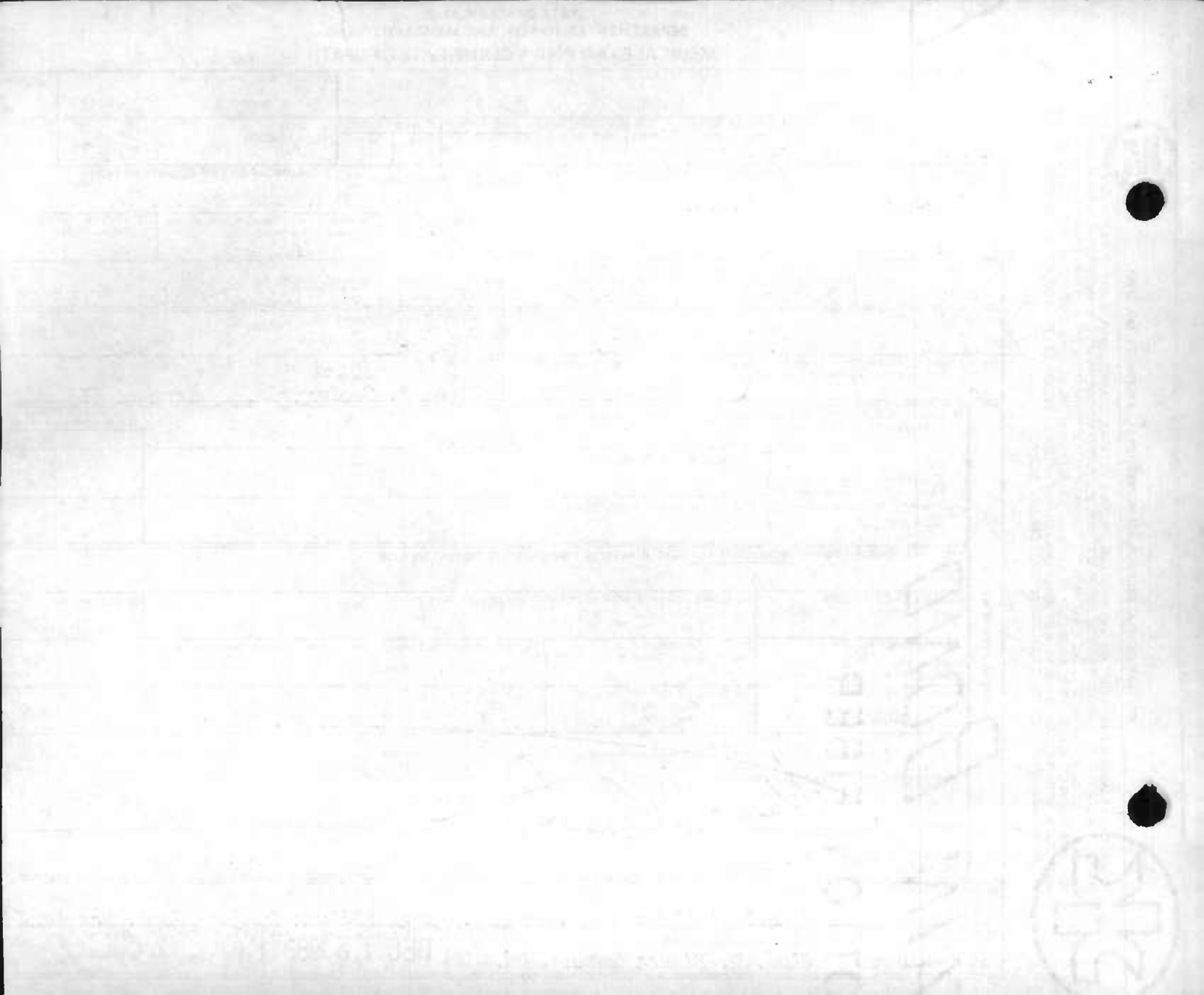


RECEIVED
OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
MILITARY MEDICAL DEPARTMENT
WASHINGTON, D. C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|------------------|---|---|---|------------------|---|--|---|---------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Nancy Jeanne Dooley | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
12 5 1983 | | 2b. HOUR
M | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
June 13 1948 | 6. AGE (IN YEARS)
LAST BIRTHDAY
35 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12 5 1983 | 7d. HOUR
M
7:30P | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
California | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Georgia Ave & Spring Street (parking lot) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)
Biochemist | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5109 Yosemite Drive 20853 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James L. Delozier | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marjorie Dudley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
223-72-2895 | | 17. INFORMANT
Husband
Wilbur J. Dooley, Jr. | | | | ADDRESS
Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Multiple gunshot wounds</u>
9654
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR <u>6-7 P.M.</u> MONTH DAY YEAR
12 5 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject shot | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
parking lot | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Georgia Ave & Spring St, Silver Spring, Mont, MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Malignant causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Deputy Chief | | | | DATE SIGNED
12/5/83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Thomas D. Smith, M.D. | | | | ADDRESS
111 Penn St. Balto., MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Dec 10 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Mont, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins | | | | ADDRESS
500 University Blvd., W. Silver Spring, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1983 | | 25b. REGISTRAR'S SIGNATURE
 | |

BP



1. FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

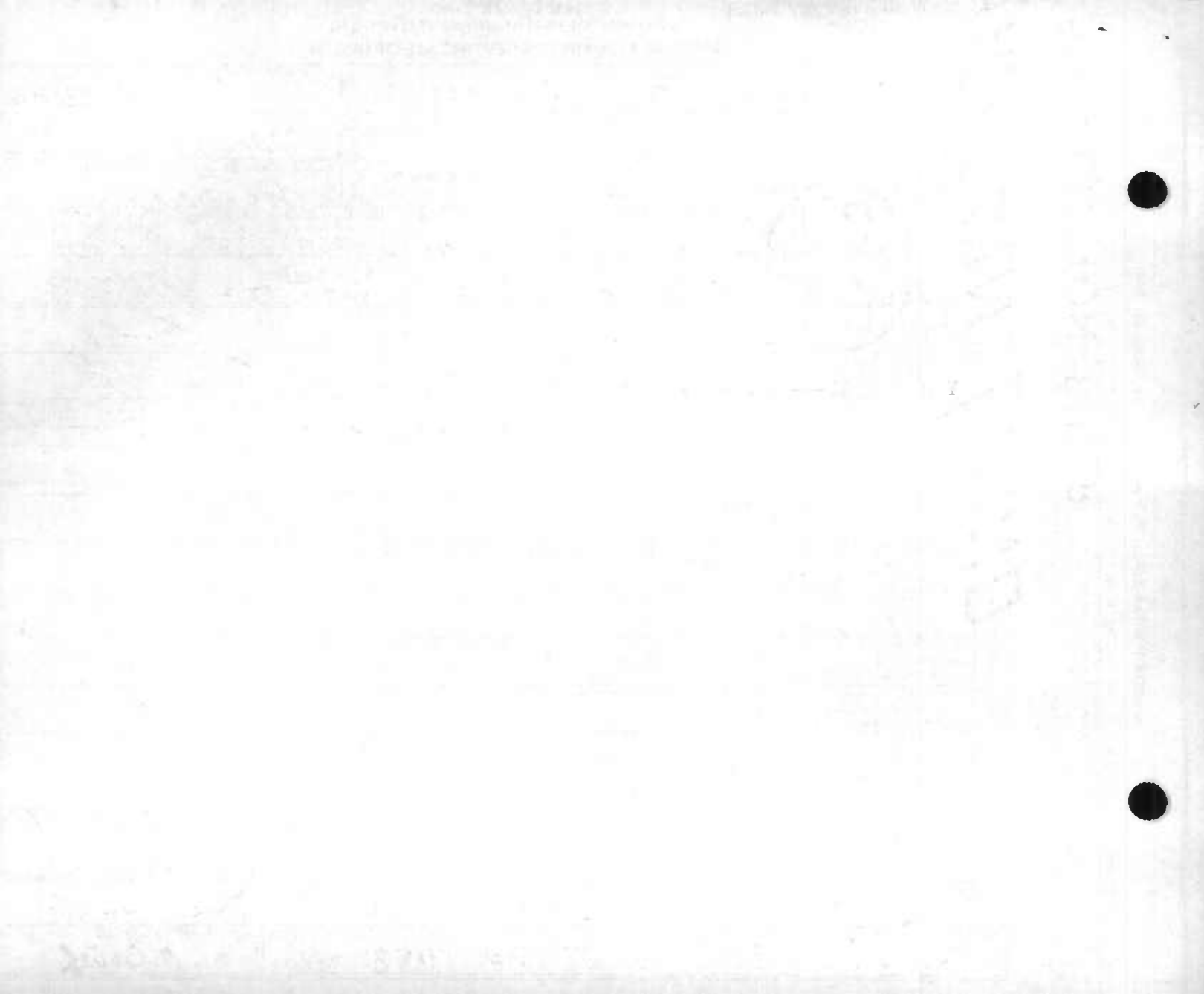
REG. NO.

| | | | | | | | | |
|--|------------------|---|---|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Thomas E. Dooley | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH 12 DAY 25 YEAR 1983 | | | 2b. HOUR 1426 | | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH
MONTH June DAY 22 YEAR 1945 | 6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS. | IF UNDER 1 YR.
MONTHS 0 DAYS 0 HOURS 0 MIN. | IF UNDER 24 HRS.
HOURS 0 MIN. | 2c. DATE PRONOUNCED DEAD Dec 25 1983 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) Grady Grove Advent. Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cost Analyst | | 12b. KIND OF BUSINESS OR INDUSTRY Government |
| 13a. STATE Md | | 13b. COUNTY Mont | 13c. CITY OR TOWN Gaithersburg | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13e. STREET ADDRESS 736 Tiffany Ct (20878) | | | |
| 14. FATHER'S NAME
FIRST Benjamin MIDDLE C. LAST Dooley | | | 15. MOTHER'S MAIDEN NAME
FIRST Margaret MIDDLE Carter LAST Carter | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) 11-4-56 10-3-64 | | 16b. SOCIAL SECURITY NO. 219-34-8756 | | 17. INFORMANT ADDRESS Betty L. Dooley, same as #13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF
4291
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
None | | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers | | TITLE (SPECIFY) M.D. | | MEDICAL EXAMINER | | | DATE SIGNED Dec 25, 1983 | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. | | ADDRESS 1919 Seminary Road Silver Spring, Maryland 20910 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Dec 27, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | | 23d. LOCATION
CITY OR TOWN Alexandria COUNTY Virginia STATE | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 3 - 1984 | | 25b. REGISTRAR'S SIGNATURE Joan J. Canick | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS ANTICIPATED. IT SHOULD BE EXECUTED IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

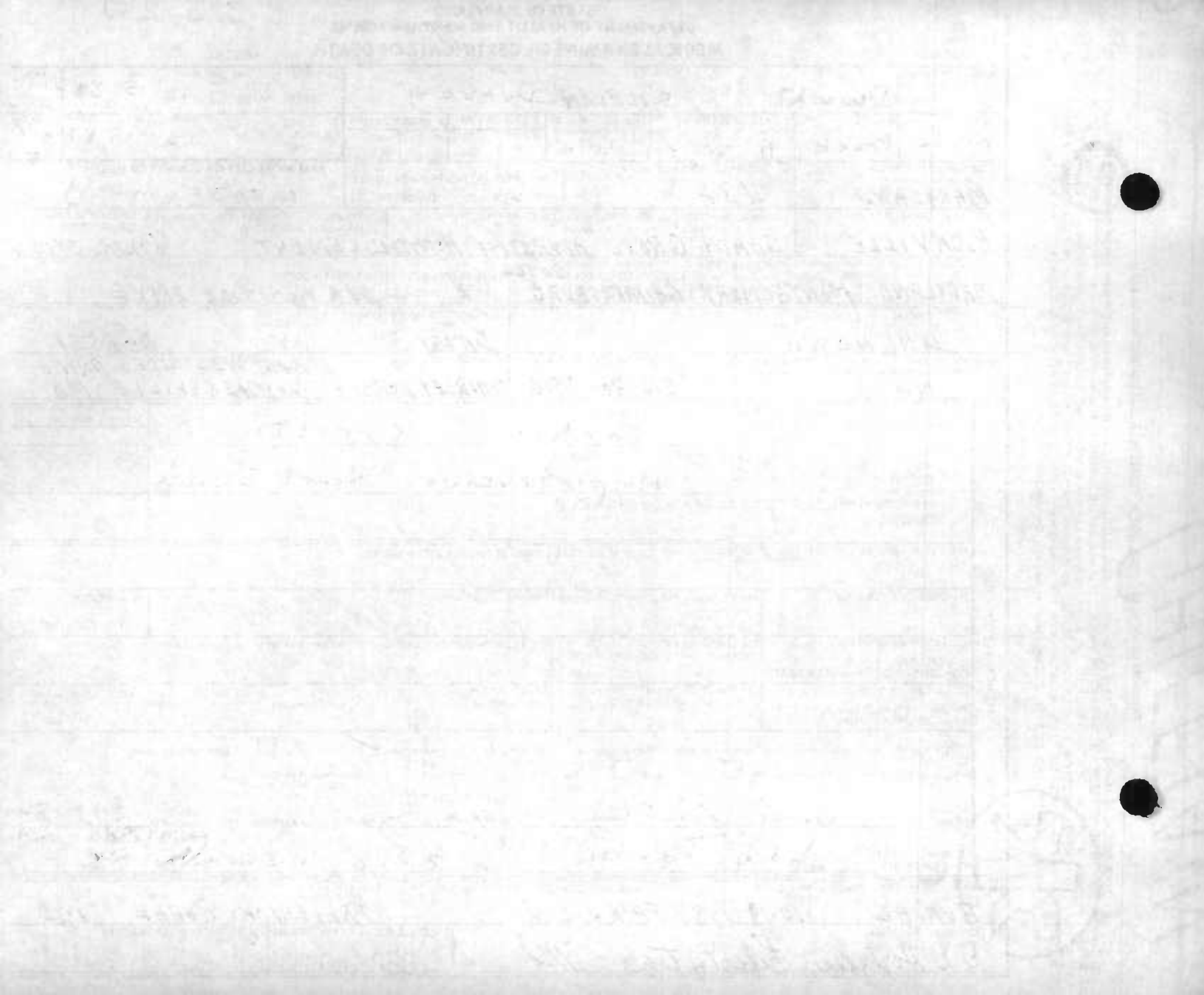
DMMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|-------------------------|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Dwight KILBURN Dorsey | | | 2a. DATE OF KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 12 15 1983 | | | 2b. HOUR 8 PM | | |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR 11 30 34 | 6. AGE (IN YEARS LAST BIRTHDAY)
49 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 12 15 1983 | 7d. HOUR 8 PM | |
| 7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST HOSPITAL CEMENT | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CEMENT | | 12b. KIND OF BUSINESS OR INDUSTRY
CONSTRUCTION |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
GAITHERSBURG | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
343 WESTSIDE DRIVE 20760 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DAISY Y DORSEY | | | 17. INFORMANT
SHIRLEY DORSEY GAITHERSVILLE MD | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
216-30-3316 | | | 17. ADDRESS
343 WESTSIDE DRIVE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
4029
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) Hypertensive Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
John Tanber | | | TITLE (SPECIFY)
M.D. Deputy | | | MEDICAL EXAMINER
Bethesda md. | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
John Tanber | | | ADDRESS
8218 WISCONSIN AVE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
12-19-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
FAIRVIEW | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
FREDERICK RURAL MD | |
| 24. FUNERAL DIRECTOR
(NAME)
D D Hartzler | | | ADDRESS
Libertytown Md | | | 25a. DATE REC'D. BY REGISTRAR
DEC 20 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carver |



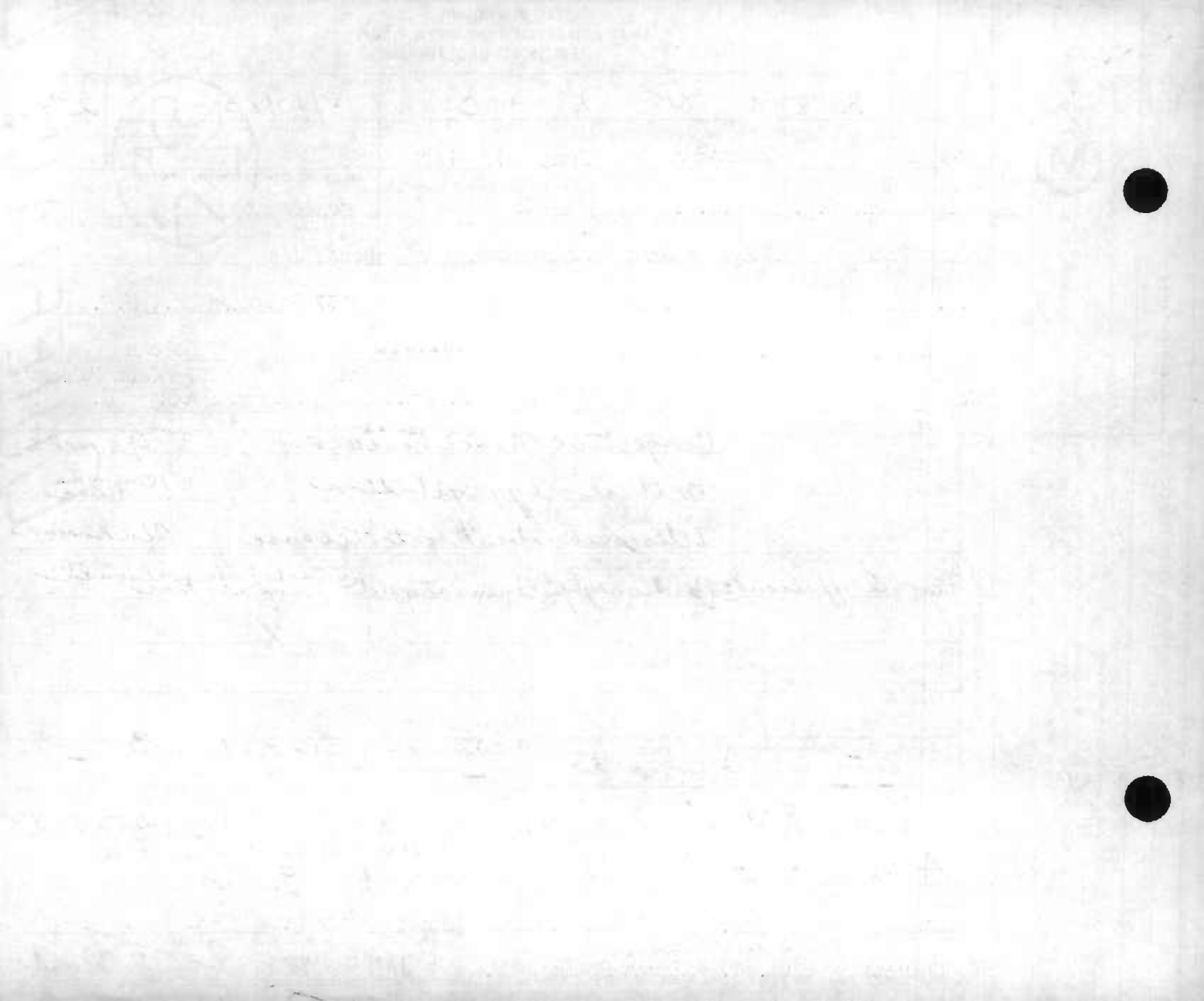
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) BERTHA M. ECCARD | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 12/27/83 | | | 2b. HOUR
2:20 P.M. | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR June 17 1887 | | 6. AGE (IN YEARS LAST BIRTHDAY)
96 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sligo Gardens Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
D.C. | | 13b. COUNTY | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3737 Legation St., N.W. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George W. Holt | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN Osborn | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
577-36-2108 | | 17. INFORMANT
Sister | | ADDRESS 9007 Alton Parkway Silver Spring, Md. 20910 | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4140 Congestive Heart Failure | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
9 weeks | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b) Mitral regurgitation | | | | | | | | | | 10 weeks Plus | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease | | | | | | | | | | Unknown | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
Pleural effusion, Cardiac myxoma, B. meningitidis, (4) Cerebral infarction | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-22 19 83 to 12-27 19 83 , that (I) (we) last saw the deceased alive on 12-26 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Alan R. Gair | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-27-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Alan R. Gair MD | | | | 22e. ADDRESS
11700 Old Columbia Pike Silver Spring, Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 30, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pr. Geo. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins | | | | ADDRESS
500 University Blvd., W. Silver Spring, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 6 1984 | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | |

999999



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|---|--|--|
| 1. FOR
STATE
REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) MARIE L. ELBERS | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 29 83 | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 5 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 | | 7b. HOUR
6:30 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Lutheran Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
9701 Fields Rd. 20878 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Clarence - Wilson | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Garrie - Lockwood | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | | 16b. SOCIAL SECURITY NO.
063-40-5570JI | | 17. INFORMANT
Gerald L. Elbers | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CLINICAL ASPIRATION PNEUMONIA
2900
DUE TO, OR AS A CONSEQUENCE OF
(b) Advanced Senile Dementia
DUE TO, OR AS A CONSEQUENCE OF
(c) 2900
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 19 81 , to 29 Dec 19 83 , that (I) (we) last saw the deceased alive on 24 Dec 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Thomas E. Elbery, MD | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
12/30/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR
Gartner Sandison
Gartner Sandison F.H. Gaithersburg, Md. 20877 | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1984 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | |

UNION
MAY
1917



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE CLERK AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

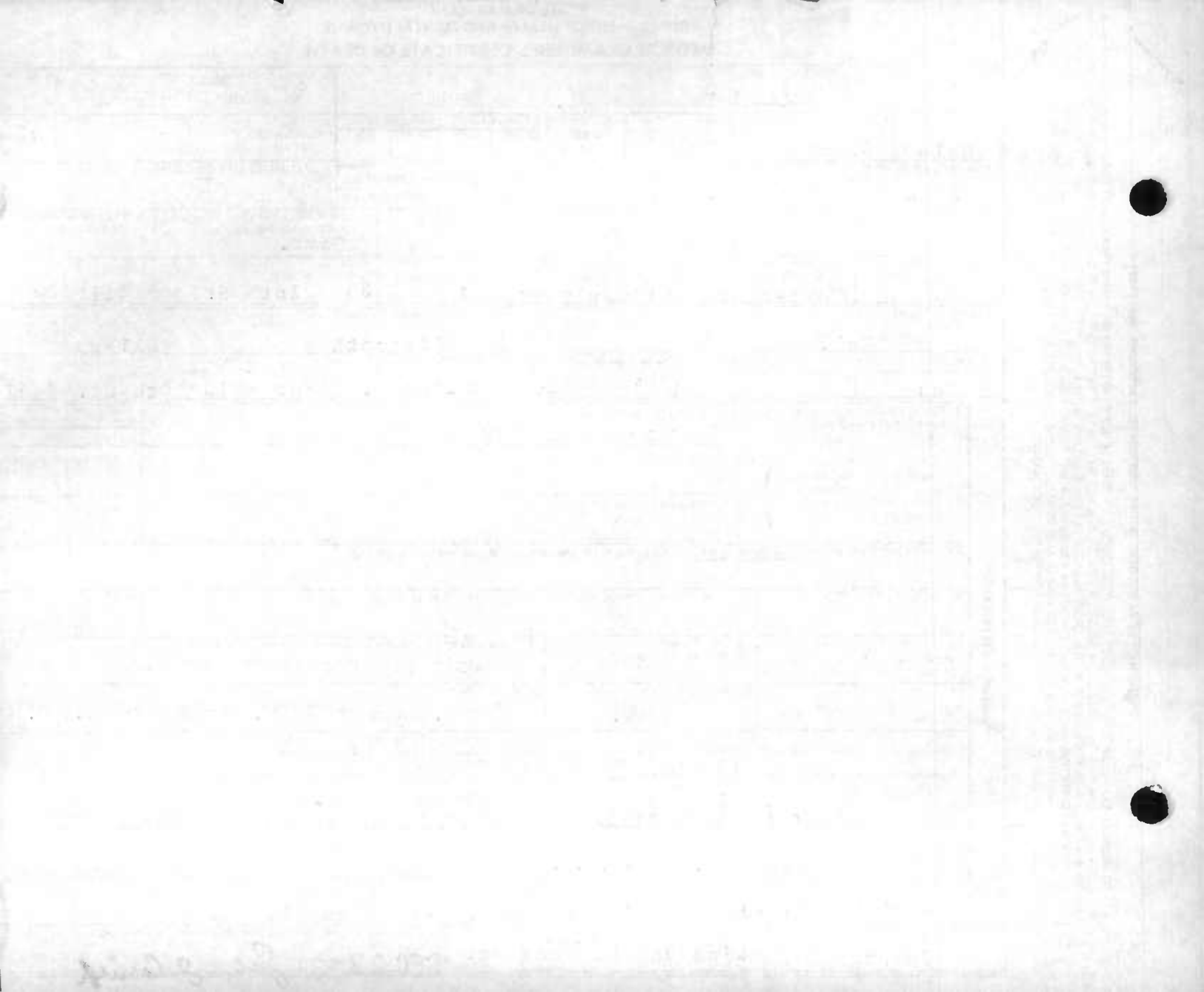
BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|-------------------------------------|--|--|--|-------------------|--|--|--|-----------------------------------|--|--|--|---------------------------|--|---|--|--|--|---------------------|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 2. DECEASED NAME
(TYPE OR PRINT) | | | | | | | | | | 3. DATE KNOWN
OF DEATH | | 4. MONTH | | 5. DAY | | 6. YEAR | | 7. HOUR | | | |
| | | CLAUDIUS L. ELLER | | | | | | | | | | 12-12-83 | | 12 | | 12 | | 83 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 1 YR. | | 8. IF UNDER 24 HRS. | | 9. DATE PRONOUNCED | | 10. MONTH | | 11. DAY | | 12. YEAR | | 13. HOUR | | | |
| Male | | Black | | 10-23-1936 | | 47 YRS. | | | | | | 12-12-83 | | 12 | | 12 | | 83 | | 9:26 | | | |
| 14. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 15. CITIZEN OF WHAT COUNTRY? | | | | 16. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 17. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| North Carolina | | | | U.S.A. | | | | | | | | Montgomery County | | | | | | | | | | | |
| 18. CITY OR TOWN OF DEATH | | | | 19. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 20. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 21. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Bethesda | | | | Suburban Hospital | | | | | | | | Govt. | | | | | | | | | | | |
| 22. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 23. STATE | | | | 24. COUNTY | | | | 25. CITY OR TOWN | | | | 26. INSIDE CITY LIMITS? | | | | 27. STREET ADDRESS | | | |
| | | | | Md. | | | | Montgomery | | | | Silver Spring | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 8510 16th St. # 411 | | | |
| 28. FATHER'S NAME | | | | 29. MOTHER'S MAIDEN NAME | | | | 30. FATHER'S FIRST | | | | 31. MOTHER'S FIRST | | | | 32. FATHER'S MIDDLE | | | | 33. MOTHER'S MIDDLE | | | |
| Unk. | | | | Elizabeth | | | | | | | | | | | | Eller | | | | | | | |
| 34. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | 35. SOCIAL SECURITY NO. | | | | 36. INFORMANT | | | | 37. ADDRESS | | | | 38. DATE | | | | | | | |
| Yes | | | | 245-50-1263 | | | | Loudia M. Eller | | | | 8510 16th St. # 41 | | | | | | | | | | | |
| 39. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
8147 IMMEDIATE CAUSE (a) Thoraco-abdominal trauma
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | |
| 39a. DATE OF OPERATION | | | | 39b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 39c. AUTOPSY? | | | | | | | |
| | | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 40a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 40b. TIME OF INJURY
HOUR AM MONTH DAY YEAR
8:15AM 12-12-83 | | | | 40c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)
pedestrian struck by an auto(s) | | | | | | | | | | | | | | | |
| 41a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 41b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
hwy. | | | | 41c. LOCATION
STREET CITY OR TOWN COUNTY STATE
1700blk. East-West Hwy. Montgomery Co., Md. | | | | | | | | | | | | | | | |
| 42. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Margarita A. Korell | | | | | | | | | | TITLE (SPECIFY)
M.D. Assistant | | | | DATE SIGNED
12-13-83 | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | | | | | | | ADDRESS
111 Penn Street | | | | | | | | | | | | | |
| 43a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 43b. DATE | | | | 43c. NAME OF CEMETERY OR CREMATORY | | | | 43d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | | | 12-16-83 | | | | Md. Nat. Mem. Park | | | | Laurel, Md. | | | | | | | | | | | |
| 44. FUNERAL DIRECTOR
NAME | | | | | | | | | | 45. DATE REC'D. BY REGISTRAR | | | | 46. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Johnson & Jenkins | | | | | | | | | | DEC 22 1983 | | | | John J. Coniff | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|------------------------------------|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Jack - Ender | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 1, 1983 | | | 2b. HOUR
2:02p M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
February 18, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk - Bookkeeper | | 12b. KIND OF BUSINESS OR INDUSTRY
Liquor | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Max - Amdur | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah - (Unknown) | | | 13e. STREET ADDRESS
1220 Blair Mill Rd. #603 (20910) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | 17. INFORMANT
ADDRESS
Mark Davis 126 Northway Rd. Greenbelt, Md. | | | | | |

| | | | |
|---|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
4249
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Valvular Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
30 Min. | |
|---|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (the deceased) attended the deceased from Nov. 23, 1983 to Dec. 1, 1983 that (I) last saw the deceased alive on Dec. 1, 1983, and that in (my) best opinion death occurred on the date and hour and from the causes stated above. (I) viewed (did) not view the body after death.

| | | | | | |
|--|--|---|--|----------------------------------|--|
| 21a. SIGNATURE
<u>Penny L. Bisk</u> | | DEGREE | | 22c. DATE SIGNED
Dec. 1, 1983 | |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Penny L. Bisk, M.D. | | 22b. ADDRESS
10313 Georgia Ave. Silver Spring, Md. | | | |

| | | | | | | | |
|--|--|-----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec/6/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Beth Kehillah Cemetery Pleasantville, New Jersey | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
|--|--|-----------------------|--|--|--|--|--|

| | | | | | |
|---|--|---|--|---|--|
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Chambers Funeral Home Silver Spring, Maryland | | 25a. DATE REC'D: BY REGISTRAR
DEC 7 1983 | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Connel</u> | |
|---|--|---|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | | | | |
|---|--|--|--|--|---|--|---|--|----------------|
| 1. FOR
STATE
REGISTRAR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR |
| 1. DECEASED NAME FIRST MIDDLE LAST
<i>Gustav Harold Emery</i> | | | | | <i>December 8, 1983</i> | | | | <i>10:20</i> M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | |
| <i>Male</i> | <i>White</i> | <i>July 17, 1896</i> | | <i>87</i> YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| <i>Crawfordsville Indiana</i> | <i>U.S.A.</i> | | | <i>Montgomery</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| <i>Cherry Chase</i> | <i>7010 Hillcrest Place</i> | | | <i>Attorney</i> | | <i>Patents</i> | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN | | | | | 13e. STREET ADDRESS | | | | |
| <i>Md 20815 Montgomery</i> | | | | | <i>Cherry Chase</i> | | <i>7010 Hillcrest Place</i> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| <i>William O. Emery</i> | | <i>Augusta Roetzel</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMATION as item 16 ADDRESS | | | | | |
| <i>Yes</i> | | <i>W.W.I. 1918 218-34-</i> | | <i>6668-A Wife - Kathryn Emery</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line by (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| <i>1850 Cardio-respiratory arrest</i> | | | | | | | | <i>immediate</i> | |
| DUE TO, OR AS A CONSEQUENCE OF (b): | | | | | | | | | |
| <i>Cancer of prostate</i> | | | | | | | | <i>1 1/2 years</i> | |
| DUE TO, OR AS A CONSEQUENCE OF (c): | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>April</i> 19 <i>1979</i> , to <i>Nov 28</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>Nov 28</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| <i>Allen S. O'Neill M.D.</i> | | | | | | | | <i>Dec 8, 1983</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| <i>Allen S. O'Neill, M.D.</i> | | | | <i>8601 Old Georgetown Rd. Bethesda Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| <i>Burial</i> | | <i>12/10/83</i> | | <i>Ft. Lincoln Cem.</i> | | <i>Brentwood, Maryland</i> | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 24b. ADDRESS | | 24c. DATE RECEIVED BY REGISTRAR (A) REGISTRAR'S SIGNATURE | | | |
| <i>Joseph Gawler's Sons, Inc.</i> | | | | <i>5130 Wisc. Ave. N.W. Wash., DC 20016</i> | | <i>DEC 15 1983 John J. Gawler</i> | | | |



7130 Ave. N.E., Wash., D.C. 20011
 General Electric Corp., Inc.
 1000 1st St. N.E., Wash., D.C. 20002

DEC 1 1963
 General Electric Corp.

Weyland

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|--|---|---|---|--|------------------------------------|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ELOISE WALKER ENGLISH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DEC 27 1983 | | | 2b. HOUR P.
2:35 AM | | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
JUL 12 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GEORGIA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
at HOME | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
VA 22101 | | | | | 13b. COUNTY
FAIRFAX | | 13c. CITY OR TOWN
MCLEAN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PRESTON BROOKS WALKER | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LILLIE HALL | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
579-60-1242 | | 17. INFORMANT
11025 STANMORE DRIVE ELOISE DAVIES POTOMAC, MD 20854 | | | | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) S/P MYOCARDIAL INFARCTION
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION
NA | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from **DEC 16 1983**, to **DEC 27 1983**, that (I) (we) lost
saw the deceased alive on **DEC 27 1983**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|---|--|-------------------------------------|--|--|--|
| 27b. SIGNATURE
<i>E. Killeavy</i> | | DEGREE
MD | | 27c. DATE SIGNED
28 Dec 83 | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)
E. KILLEAVY | | 27e. ADDRESS
LT, MC, USNR | | 27f. ADDRESS
NAVAL HOSPITAL, BETHESDA, MD. 20814 | |

| | | | | | | | |
|---|--|------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12-30-83 | | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ARLINGTON ARLINGTON VA. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
JOS. GAWLERS' SONS 5130 WISC. AVE. NW. WASH., D.C. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 3 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. G...</i> | |

2000 1000 1000 1000 1000

1000 1000 1000 1000 1000

1000 1000 1000 1000 1000

1000 1000 1000 1000 1000

1000 1000 1000 1000 1000

1000 1000 1000 1000 1000

1000 1000 1000 1000 1000

1000 1000 1000 1000 1000

1000 1000 1000 1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

3336-27

FOR
STATE
REGISTRAR

| | | | | | |
|--|-----------------------------|--|---|---|----------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
Agnes Evans | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 15, 1983 | | 2b. HOUR
11:00AM |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
August 4, 1881 | | 6. AGE (IN YEARS LAST BIRTHDAY)
102 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4839 Langdrum Lane | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Chevy Chase | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Day McChesney | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Agnes Fuller | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216 46 0799 | | 17. INFORMANT
ADDRESS
Barbara Evans Daughter same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
4140
DUE TO, OR AS A CONSEQUENCE OF
(b) Generalized arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) Decubitus ulcer of Sacrum
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 years
15 years
10 days | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) this hospital attended the deceased from Dec. 6, 1950 , to Dec. 15, 1983 , that (I) last saw the deceased alive on Dec. 10, 1983 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) we (did) not view the body after death. | | | | | |
| 22b. SIGNATURE
Thomas S. Sappington | | DEGREE
MD | | 22c. DATE SIGNED
Dec. 15, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas S. Sappington, M.D. | | 22e. ADDRESS
N.W. 2233 Wisc. Ave., Washington, D.C. 20007 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Dec. 16, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria Virginia | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1983 | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | 24b. ADDRESS
P.A., Bethesda, Maryland | | 25b. REGISTRAR'S SIGNATURE
John J. Smith | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 12/29/83 | | 2:25 P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MALE | | CAUCASIAN | | MARCH 20 1915 | | 68 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| NEW YORK | | U.S.A. | | MONTGOMERY | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | | Holy Cross Hospital | | PATROLMAN | | BUREAU OF STANDARDS | |
| 13a. STATE | | 13b. COUNTY | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| MARYLAND | | MONTGOMERY | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 14017 LONDON LANE 20853 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| VINCENZO | | ANNA | | YES | | 054-05-2529 | |
| 17. INFORMANT | | ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| CHARLOTTE E. FABIANO | | WIFE SAME AS 13 | | PART I. DEATH WAS CAUSED BY: | | | |
| | | | | IMMEDIATE CAUSE (a) | | | |
| | | | | 4100 | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | | | (b) myocardial infarction | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | | | (c) Coronary Thrombosis | | | |
| | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | |
| | | | | gastrointestinal bleeding | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | 12-28 1983 to 12-29 1983 | | 22c. DATE SIGNED | | | |
| above, (I) (we) (did) (did not) view the body after death. | | | | 12-29-83 | | | |
| 22a. SIGNATURE | | DEGREE | | 22b. ADDRESS | | | |
| LEONARD L. DEITZ | | | | 1900 FOREST GLEN RD SILVER SPRING, MD. 20910 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| BURIAL | | JAN. 3, 1984 | | GATE OF HEAVEN | | SILVER SPRING MONT. MD. | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| FRANCIS J. COLLINS | | JAN 6 1984 | | J. J. Collins | | | |
| 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes at the top of the page, including the word "Lecture" and some illegible scribbles.

Handwritten notes in the middle section, appearing as several lines of cursive script.

Handwritten notes at the bottom of the page, including a circular stamp on the left and some illegible text.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARY ELLEN FARRINGTON | | | 2a. DATE OF DEATH MONTH DAY YEAR
DEC 31, 1983 | | 2b. HOUR
3:40 A.M. |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH MONTH DAY YEAR
JULY 22, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS
86 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
KENSINGTON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
KENSINGTON GARDENS NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. NAVY DEPT |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
DARNESTOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
MICHAEL J. FARRINGTON | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ANNA C. COLLINS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
579 60 1672 | | 17. INFORMANT ADDRESS
MARY MOFFETT SAME AS 13 COUSIN | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intractable Vomiting and dehydration
DUE TO, OR AS A CONSEQUENCE OF:
(b) Chronic Inanition
DUE TO, OR AS A CONSEQUENCE OF:
(c) Organic brain syndrome | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 days
One year
One year |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 3109 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHERE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 6, 1983 to December 31, 1983 , that (I) (we) last saw the deceased on June 6, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | |
| 22b. SIGNATURE
James E. Wilson, Jr. | | DEGREE
MD. | | 22c. DATE SIGNED
12/31/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James E. Wilson, Jr. M.D. | | 22e. ADDRESS
1125 Rockville Pike, Ste 103, Rockville Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
1/3/84 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. OLIVET CEMETERY | |
| 23d. LOCATION CITY OR TOWN
WASHINGTON, D.C. | | 23e. COUNTY
20852 | | 23f. STATE | |
| 24. FUNERAL DIRECTOR NAME
FRANCIS J. COLLINS | | 24b. ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | 25. DATE RECEIVED BY REGISTRAR (DATE OF REGISTRAR'S SIGNATURE)
JAN 6 1984 | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please review carefully pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked unknown, item 18 shows any injury, or other traumatic event, the medical examiner should be notified immediately.

INDEXED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|---|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME
(TYPE OR PRINT) ELIZABETH B. FAHEY | | 2a. DATE OF DEATH MONTH DAY YEAR
12-14-83 | |
| 3 SEX
Female | | | 4 RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
2-25-1896 | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. AGE (IN YEARS LAST BIRTHDAY)
87 | |
| 9. CITY OR TOWN OF DEATH
BETHESDA | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FERNWOOD House | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Sidney L. Bowman | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Edna Myers | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | |
| 17. SOCIAL SECURITY NO.
578-50-5605 | | | 18. INFORMANT
Dr. James T. Fahey / Imperial Beach, Calif. | | ADDRESS 762 9th St. Box 95 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma Ovary
1830
DUE TO, OR AS A CONSEQUENCE OF (b) with abdominal metastases
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
? months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE, DIABETES MELLITUS | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 72 to Dec 14 19 83 , that (I) was last saw the deceased alive on Dec 6 19 83 , and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (I) do not (did) not view the body after death. | | | | | | |
| 22b. SIGNATURE
Dr. W. H. DeLawter MD | | | | DEGREE
MD | | 22c. DATE SIGNED
12-15-83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DeWitt E. DeLawter | | | | 22e. ADDRESS
6318 Democracy Blvd Bethesda Md 20817 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-21-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Arlington, Virginia |
| 24. FUNERAL DIRECTOR NAME
Joseph Gawler's Son's, Inc. | | | | 25. DATE REC'D. BY REGISTRAR
DEC 23 1983 | | REGISTRAR'S SIGNATURE
John J. Gawler |
| 25. ADDRESS
5130 Wisconsin Avenue, N.W. Wash. D.C. | | | | | | |

Lincoln

1961-1962

House

1961

Montgomery

House

1961

1961-1962

1961

Virginia

1961-1962

1961

George Washington

1961-1962

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | |
|--|--|------------------|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Charles Francis Feevey</i> | | | | 20. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <i>Dec 23 1983</i> | | | | 2b. HOUR <i>M</i> | | | | | |
| 3. SEX <i>M</i> | | 4. RACE <i>W</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR <i>Oct 26 24</i> | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) <i>59</i> YRS. | | 7c. DATE PRONOUNCED DEAD <i>Dec 27 1983</i> | | 2d. HOUR <i>10:00</i> | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Florida</i> | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>St. L. Spr</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>250 Georgia Ave. Apt 424</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Federal Director</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Federal Ind.</i> | |
| 13a. STATE <i>Md</i> | | | | 13b. COUNTY <i>Mont</i> | | 13c. CITY OR TOWN <i>St. L. Spr</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS <i>250 Georgia Ave Apt 424</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST <i>Unknown</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST <i>Unknown</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) <i>Yes</i> | | | | 16b. SOCIAL SECURITY NO. <i>137-16-4671</i> | | 17. INFORMANT <i>Mr. Paul J. Rea, RA</i> | | | | ADDRESS <i>2564 Chain Bridge Rd Apt Fz Vienna Va 22180</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Carcinoma of Lung</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>same</i> | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
<i>None</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION <i>None</i> | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion. | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>John S. Roberts</i> | | | | TITLE (SPECIFY) <i>M.D. Dep</i> | | | | MEDICAL EXAMINER | | | | DATE SIGNED <i>Dec 27 1983</i> | |
| EXAMINER'S NAME
(TYPE OR PRINT) <i>JOHN S. ROBERTS</i> | | | | ADDRESS <i>Silver Spring, Md.</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <i>Cremation</i> | | | | 23b. DATE <i>Dec 29 1983</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Chambers Crematory</i> | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE <i>Riverdale P.E. City Maryland</i> | | | |
| 24. FUNERAL DIRECTOR
NAME <i>W. W. Chambers Co.</i> ADDRESS <i>5655 Calz Ave</i> | | | | | | 25a. DATE REC'D BY REGISTRAR <i>JAN 4 1984</i> | | 25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i> | | | | | |

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/B2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MANNE FEFFERMAN | | | 2a. DATE OF DEATH
MONTH 12 DAY 31 YEAR 83 | | | 2b. HOUR
2:20 M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH MAY DAY 15 YEAR 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
POLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MERCHANT | | 12b. KIND OF BUSINESS OR INDUSTRY
PRODUCE | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
PR. GEORGE'S | | 13c. CITY OR TOWN
HYATTSVILLE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST AVROHOM MIDDLE MOISHE LAST FEFFERMAN | | 15. MOTHER'S MAIDEN NAME
FIRST HANNA MIDDLE (UNASCERTAINABLE) LAST (UNASCERTAINABLE) | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO.
118-28-0394 | | 17. INFORMANT
JANET FEFFERMAN, HYATTSVILLE, MARYLAND | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

2500

DUE TO, OR AS A CONSEQUENCE OF

(b) **Diabetis mellitus**

DUE TO, OR AS A CONSEQUENCE OF

(c) **arteriosclerotic cardiovascular disease**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**2 weeks**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (we) based on 31 DEC 1983 to DEC 31 1983 that (we) lost
saw the deceased alive on 31 DEC 1983 , and that in (our) opinion death occurred on the date and hour and from the causes stated
above, (I/we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Walter E. Goetz MD | | | | 22c. DATE SIGNED
1 JAN 84 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
WALTER E. GOETZ MD | | | | 22f. ADDRESS
2309 SHOREFIELD RD WHEATON MD | | | |

| | | | | | | | |
|--|--|------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
1/3/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
RIVERSIDE CEMETERY | | 23d. LOCATION
CITY OR TOWN LODI COUNTY NEW JERSEY STATE NEW JERSEY | |
| 24. DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1984 | | 25b. REGISTRAR'S SIGNATURE
John J. Smith | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-1-1984

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the office of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROSE G Feigenbaum | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-16-83 | | 2b. HOUR 7:52 AM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 27, 1885 | | 6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery, MD. | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter Glaaser | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) ----- | | | |
| 16b. SOCIAL SECURITY NO. 212-52-5650T | | 17. INFORMANT ADDRESS Rockville, Md. 20852
J. Walter Feigenbaum; 11918 Renwood Lane; | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Uremia of renal failure
DUE TO, OR AS A CONSEQUENCE OF (c) Urinary bladder carcinoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1889
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
2 weeks
unknown | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/16 , 19 83 , to 12/16 , 19 83 , that AT (we) last saw the deceased alive on 12/16 , 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) JOEL A. RABSKIN, MD | | | | 22c. DATE SIGNED 12-16-83 | | 22d. ADDRESS 58 W. EDMONSON DRIVE ROCKVILLE MD 20852 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/18/83 | | 23c. NAME OF CEMETERY OR CREMATORY Wash. Hebrew Cong. Mem. Park; Washington, D.C. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR DANZANSKY-GOLDBERG MEMORIAL CHAPELS | | | | 25a. DATE REC'D. BY REGISTRAR 20. 1983 | | | |
| NAME 1170 Rockville Pike; Rockville, Maryland 20852 | | | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | |

BP _____

CHIEF OF BUREAU

CHIEF OF BUREAU

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at 473-8633.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|--|---|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
REBA BRYNOL FEINBERG | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 18, 1983 | | 2b. HOUR
4:40A M | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
December 21, 1954 | | 6. AGE (IN YEARS LAST BIRTHDAY)
28 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash., D.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Clinical Center NIH, The | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesperson | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. Store | |
| 13a. STATE
Maryland | 13b. COUNTY | 13c. CITY OR TOWN
Wheaton | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
12915 Goodhill Rd 20906 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel Feinberg | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Esther Hecht | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
XXXX 215-58-9710 | | 17. INFORMANT ADDRESS
Mr. Sam Feinberg, father, same as patient | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hodgkin's disease in mediastinal and para-aortic lymph nodes</u>
2016 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 27, 1983</u> , to <u>December 18, 1983</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>December 18, 1983</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | | |
| 22b. SIGNATURE
<i>Neil J. Clendenin</i> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/18/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Neil J. Clendenin MD | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, MD 20205 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/19/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Lebanon Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hyattsville, Md. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Danzansky-Goldberg Chapels; 1170 Rockville Pike Rockville, Md. | | | | | | |

BP _____

DEC 21 1983 REGISTRAR'S SIGNATURE
John J. Gandy

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

| No. | | Name | | Origin | | Date | | Remarks | |
|-----|--|------|--|--------|--|------|--|---------|--|
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Ethel | | | FIRST MIDDLE LAST Feldman | | | 2a. DATE OF DEATH MONTH DAY YEAR 12/10/83 | | | 2b. HOUR 1:05 PM | | |
| 3. SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 31, 1919 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY ----- | | |
| 13a. STATE Maryland | | | 13b. COUNTY Montgomery | | | 13c. CITY OR TOWN Sil. Spg. | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Bernard Rosenblum | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Seigel | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 151-10-4866 | | |
| 17. INFORMANT Samuel Feldman; 1902 Reedie Drive | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
3989
DUE TO, OR AS A CONSEQUENCE OF (b) Rheumatic heart disease
DUE TO, OR AS A CONSEQUENCE OF (c) -----
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days
50 yrs. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Acute bronchitis | | | | | | | | | | | |

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 7 , 19 77 , to 12/10 , 19 83 , that (we) lost saw the deceased alive on 12-10 , 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Joel A. Raitskin, MD | | | | DEGREE MD | | 22c. DATE SIGNED 12-10-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOEL A. RAISKIN, MD | | | | 22e. ADDRESS 50 W. EDMONSTON DR. ROCKVILLE, MD 20852 | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12-12-1983 | | 23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden | | 23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia | |
| 24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | 25. DATE REC'D BY REGISTRAR DEC 12 1983 REGISTRAR'S SIGNATURE John J. [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner and the notified coroner must be notified.

1

1. $\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ESTERA A. FIKS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 17 83 | | | 2b. HOUR
MIN.
3:30 AM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 9, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Poland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Hebrew Home of Greater Washington | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Co-owner (Ret) | | 12b. KIND OF BUSINESS OR INDUSTRY
Retail Furs | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Mordechai Kluger | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Feiga Sucrekorn | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
098-24-8056 | | 17. INFORMANT
Address
Fairfax, Virginia
Leslie Fiks; 34 Waple Mobile Estate | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RENAL FAILUREAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3 mos.

5902
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **URINARY TRACT INFECTION****3 mos.**

DUE TO, OR AS A CONSEQUENCE OF

(c) **LEFT PERIPHERAL ABSCESS****18 mos.**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **no**

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 5/1/83 to 12/17/83 , that (1) (we) last saw the deceased alive on 12/17/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) saw the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert L. Rosenberg | | | | DEGREE
MD | | 22c. DATE SIGNED
12/17/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT L. ROSENBERG, MD | | | | 22e. ADDRESS
10313 GEORGE AVE, SILVER SPRING, MD. 20902 | | | |

| | | | | | | | |
|---|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-20-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Montefiore Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Springfield, L.I., New York | |
|---|--|------------------------------|--|--|--|--|--|

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|--|--|--|--|---|--|
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | DATE REC'D. BY REGISTRAR
DEC 20 1983 | | REGISTRAR'S SIGNATURE
Sam J. Conner | |
|--|--|--|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

THE UNIVERSITY OF CHICAGO
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MURRAY | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 6, 1983 | | | 2b. HOUR
2:30p.m. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 1, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
0 0 0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
10401 Grosvenor Place | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Owner (Retired) | | 12b. KIND OF BUSINESS OR INDUSTRY
Restaurant | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
10401 Grosvenor Place | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert Fischer | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ella Wolff | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT
ADDRESS
Gaithersburg, Md.
Marlynn Goren; 15213 Winesap Drive | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CONGESTIVE HEART FAILURE**
4409
DUE TO, OR AS A CONSEQUENCE OF
(b) **ARTERIO SCLEROSIS**
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

MALIGNANT BRAIN TUMOR

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10 YRS , 19____, to _____, 19____, that (I) (we) last
saw the deceased alive on 12-6 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (they) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert Kramer | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-7-1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT KRAMER, M.D. | | | | 22e. ADDRESS
10313 Georgia Avenue; Silver Spring, Md. | | | |

| | | | | | | | |
|--|--|-------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-8-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Judean Memorial Gardens | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Olney, Montgomery, Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advice obtained.

BP _____

DEC 12 1983 REGISTRAR'S SIGNATURE
John J. Canine

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Samuel A Fisher | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 07, 83 | | | 2b. HOUR
0140 M | | | |
| 3. SEX
MALE | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 21, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
66 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md | | 13b. COUNTY
Montg | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
17060 King James Way 20877 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MAURICE K. Fisher Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dora Simms | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
216-18-0790 | | 17. INFORMANT
ADDRESS
Florence Duffin (sister) 259 Clopper Rd. G'burg Md. | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
3451
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) anoxic Encephalopathy
DUE TO, OR AS A CONSEQUENCE OF
(c) Grand mal Epilepsy | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hours
3 days
years | |
|---|--|--|--|

| | | | |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
Adult type Diabetes mellitus Hypertensive cardiovascular disease | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |

| | | | | | |
|--|--|--|--|---|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

| | | | | | | | |
|--|--|--|--|---|--|------------------------------------|--|
| 22a. I certify that (I) (the hospital) attended the deceased from July 19 71 to Dec 7 19 83 , that (I) (we) last saw the deceased alive on Dec 6 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | 22b. SIGNATURE
John G. Fawcett | | DEGREE
ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>
PHYSICIAN DIRECTOR PHYSICIAN | | 22c. DATE SIGNED
12/7/83 | |
|--|--|--|--|---|--|------------------------------------|--|

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN G. FAWCETT, M.D. | | 22e. ADDRESS
16610 Sugarland Rd, Dawsonville, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
BURIAL | | 23b. DATE
12-13-83 | | 23c. NAME OF CEMETERY OR CREMATION
Mt. Zion Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dickerson, Montg Md. | |
| 24. FUNERAL DIRECTOR
NAME
George R. Snowden | | 24b. ADDRESS
2460 N. Wash. St. Rockville, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 12 1983 | | 25b. REGISTRAR'S SIGNATURE
Jan G. Grier | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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10/21/1917

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10/21/1917

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR | | 7b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | DECEMBER 13 1983 | |
| MARY DELORES FORD | | | | 1:22 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | |
| FEMALE | | CAUCASIAN | | DECEMBER 8 1926 | |
| 6. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| ILLINOIS | | UNITED STATES | | 57 YRS. | |
| CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| BETHESDA | | NAVAL HOSPITAL | | MONTGOMERY MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. CITY OR TOWN | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE | | ANNANDALE | | HOMEMAKER | |
| VIRGINIA | | FAIRFAX | | 13b. STREET ADDRESS / ZIP CODE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | 8625 ORDINARY WAY 99999 | |
| RALPH KENNEDY | | EUNICE KAISER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 351-18-4389 | | JOHN R. FORD, 8625 ORDINARY WAY, ANNANDALE, VA 22003 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>WIDELY METASTATIC OVARIAN CARCINOMA</u> | | | | | |
| 1830 DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| 22 NOV 83 | | CUTDOWN R INTERNAL JUGULAR VEIN | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | P.M. 19 | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 18</u> , 19 <u>83</u> , to <u>DECEMBER 13</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>DECEMBER 13</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 27b. SIGNATURE | | DEGREE | | 27c. DATE SIGNED | |
| <u>BH Strand</u> | | MD | | 14 DEC 83 | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 27e. ADDRESS | | | |
| B. H. STRAND, LCDR, MC, USN | | NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | |
| 23b. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 12-16-83 | | Arlington National | |
| 24. FUNERAL DIRECTOR
NAME | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | 25a. DATE REC'D. BY REGISTRAR | |
| Every Funeral Home | | Arlington, Virginia | | DEC 20 1983 | |
| 10565 Main St. Fairfax | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | | | | |

INDEX



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THE UNIVERSITY OF CHICAGO PRESS

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 120 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 3 3 6 4 0 | |
|--|--|---|--|---|--|---|--|---|---|---|--|
| 1- FOR STATE REGISTRAR Clarence L. Fossett | | | | | | | | | | REG. NO. | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Clarence Louis Fossett | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED Dec 6 1983 | | MONTH DAY YEAR | | 438 | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR 1905 | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS. MONTHS DAYS | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD
Dec 6 1983 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
AL | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Chesapeake | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)
Mont. General Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Clergyman | | 12b. KIND OF BUSINESS OR INDUSTRY
Church | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Chesapeake | | 13d. INSIDE CITY LIMITS
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3705 Chesapeake Dr | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Francis Marion Fossett | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ollie Victoria Thacker | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
212-36-3930 | | 17. INFORMANT
ADDRESS 10210 Greenbelt Rd.
Clarence L. Fossett, Jr. Seabrook, MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) Possible Fracture of Neck
DUE TO, OR AS A CONSEQUENCE OF
(c) Auto Accident | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
None | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Road | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Rd 18 Sandy Spring Mont. Md | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Roger, MD | | | | | | TITLE (SPECIFY)
Dep M.D. | | | MEDICAL EXAMINER
DATE SIGNED Dec 6 1983 | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Roger, MD | | | | | | ADDRESS 1919 Seminary Rd. Sil. Spg. MD 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
12/13/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Hill Cem. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Fredericksburg, VA | |
| 24. FUNERAL DIRECTOR
NAME Joseph Gawler's Sons, Inc.
ADDRESS 5130 Wisc. Ave. N.W. Wash., DC 20016 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Grier | | | |

• • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 is marked with any injury, or other traumatic event, the medical examiner must be notified at once.

Released by *W. Kenton* on *12/24/83*

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|--|---|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
George E Fouch | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/24/83 | | | 2b. HOUR
10:10a.m | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
4/11/09 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
74 | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YRS.)
Dep. Asst. Sect. Dep. Defense | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. of Defense | | |
| 13a. STATE
Md. | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Rollin J Fouch | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Nellie E. Mitchaux | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW11 | | 17. INFORMANT ADDRESS
Bealah C Fouch. Same as item 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary embolus
5929
DUE TO, OR AS A CONSEQUENCE OF (b) Venous disease, lower extremities
DUE TO, OR AS A CONSEQUENCE OF (c) 10 yrs +
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hour | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Coronary artery disease with old myocardial infarction. Diabetes Mellitus | | | | | | | | | | |
| 19a. DATE OF OPERATION
12/16/83 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Prostatectomy, left | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 11/14 , 19 74 , to 12/24 , 19 83 , that (1) (we) lost 12/17 , 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
George S. Kenton, MD | | | DEGREE | | | 22c. DATE SIGNED
12/24/83 | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GEORGE S. KENTON | | | 22e. ADDRESS
10620 Georgia Ave, Silver Spring, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
12/30/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Quantico National Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Quantico Virginia | | |
| 24. FUNERAL DIRECTOR NAME
Joseph Gawler's Sons Inc. | | | | | 24b. ADDRESS
5130 Wisc. Ave., N.W. Wash., D.C. | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1983 | | 25b. REGISTRAR'S SIGNATURE
Joan J. Connel | |

2130 Inc. v. N. N. D.C.
Joseph Switzer's Sons Inc.
12/30/1983
Nanticoke National Bank

Yes Will 229-07-7015 English C. French. name as item 13
Michigan 1 Mitchaux Helise M. S. Michigan
Mt. 30818 Contrary 30818

Ohio
X
to.t. of
D.C. v. N. N. D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARVIN HERBERT FOX | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 19, 1983 | | | 2b. HOUR
10:27^a M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 19, 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Elect. Engr. | | 12b. KIND OF BUSINESS OR INDUSTRY
Fairchild Ind | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
13113 Beaver Terrace (20853) | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Philip Favish | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Freedra Becker | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
Korea 577-40-4234 | | 17. INFORMANT ADDRESS
David Fox; 3610 Peartree Court Silver Spring, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
1629 IMMEDIATE CAUSE (a) Shock- immediate
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic lung cancer
DUE TO, OR AS A CONSEQUENCE OF
(c) 9/29/83 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept. 29, 1983 to Dec. 19, 1983 , that (I) (we) last saw the deceased alive on Dec. 17, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Stanley A. Schwartz</i> | | | | | DEGREE
ATTENDING <input checked="" type="checkbox"/> MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
Dec. 19, 1983 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stanley A. Schwartz, M.D. | | | | | 22e. ADDRESS
5454 Wisc. Ave. #835 Chevy Chase, Md 20015 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12-20-83 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Gdn. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church; Fairfax; Va. | | | |
| 24. FUNERAL DIRECTOR
NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS 1170 Rockville Pike; Rockville, Maryland 20852 | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 23 1983 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Conner</i> | | | | |

BP

RECEIVED

100-100000

(20000)

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Gladys HIGGS FRANK | | | | 2a. DATE OF DEATH
MONTH 12 DAY 10 YEAR 83 | | 2b. HOUR 4⁰⁰ M. | |
| 3. SEX F | | 4. RACE Caucasian | | 5. DATE OF BIRTH
MONTH 1 DAY 31 YEAR 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co, SS MD | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
618 MISSISSIPPI AVE. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
NA. | |
| 13a. USUAL RESIDENCE
13a. STATE MD 13a. COUNTY Mo Co 13a. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
618 Mississippi Ave. 20910 | | | |
| 14. FATHER'S NAME
FIRST HENRY MIDDLE HIGGS LAST ADELE | | | | 15. MOTHER'S MAIDEN NAME
FIRST MURPHY MIDDLE MURPHY LAST MURPHY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
577-10-8504 | | 17. INFORMANT
SHERRIE ANGE ADDRESS SAME AS 13 GRANDAUGHTER | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Mania, weight loss
4409
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Depression
DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerosis | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
weeks
years
years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: NA | | | | | | | |
| 19a. DATE OF OPERATION
- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 16 19 83 , to 12, 10 19 83 , that (I) (we) lost saw the deceased alive on Sept 16 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Fred W. Brennwald MD | | | | DEGREE MD | | 22c. DATE SIGNED
12.10.83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
F.W. BRENNWALD | | | | 22e. ADDRESS
831 University Blvd East Silver Spring | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | 23b. DATE
DEC. 11, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA ALEXANDRIA VA. | |
| 24. FUNERAL DIRECTOR
NAME FRANCIS I. COLLINS, JR. ADDRESS 500 UNIV. BLVD. W. STL. SPG. MD. 20901 | | | | 25a. DATE REC'D. BY REGISTRAR DEC 15 1983 25b. REGISTRAR'S SIGNATURE John J. Carver | | | |

FRANCIS J. COLLINS JR., SILENT PICTURE ACTRESS
5000 COLUMBIA BLVD., N.Y.
DEC. 11, 1922. HENRIETTA

ALEXANDRIA ALEXANDRIA 64

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Agnes M. Franke | | 2a. DATE OF DEATH
MONTH 12 DAY 5 YEAR 1983 | | 2b. HOUR
7:40 AM |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH 4 DAY 23 YEAR 1920 | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Nat. Geographic | 12b. KIND OF BUSINESS OR INDUSTRY
Supervisor |
| 13a. STATE
Md. | 13b. COUNTY
Mont. | 13c. CITY OR TOWN
Burtonsville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
14510 Perrywood Drive |
| 14. FATHER'S NAME
FIRST David MIDDLE K. LAST Doyle | | 15. MOTHER'S MAIDEN NAME
FIRST Helen MIDDLE Z LAST Wilhoite | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) None | | 16b. SOCIAL SECURITY NO.
579 07 5945 | | 17. INFORMANT
ADDRESS Same as 13E
John C. Franke, Jr. (Husband) |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Syndrome increased intracranial pressure
4300
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) Perforated cerebral aneurysm
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 wk |
|---|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

| | | | |
|---|---|--|--|
| 19a. DATE OF OPERATION
12/13/83 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
TRAPPING Aneurysm & Bypass | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/29 19 83 , to present 19 12/5/83 , that (I) (we) last saw the deceased alive on 12/5 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
B. Storak M.D. | | 22c. DATE SIGNED
12/5/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B. STORAK MD | | 22e. ADDRESS
5530 Wisconsin Ave. Chevy Chase, Md. | |

| | | | |
|--|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
SPECIFY Burial | 23b. DATE
12/9/83 | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | 23d. LOCATION
CITY OR TOWN COUNTY STATE
S.S. Mont. Maryland |
| 24. FUNERAL DIRECTOR
NAME Hines/Rinaldi ADDRESS 11800 New Hampshire Ave. S.S. | | 25a. DATE REC'D. BY REGISTRAR DEC 7 1983 25b. REGISTRAR'S SIGNATURE John J. Conish | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

RECEIVED
FEB 11 1961
U.S. AIR FORCE

15151
TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[illegible text follows]

[illegible text follows]

15151

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | | | | |
|---|--|--|---|--|---|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) WALTER E. FRAZIER | | | | | 2a. DATE OF DEATH MONTH 12 DAY 31 YEAR 83 | | | | | 2b. HOUR 11:31 AM | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH Jan. DAY 6 YEAR 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (Disabled) | | 12b. KIND OF BUSINESS OR INDUSTRY Farmer | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Gaithersburg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 17060 King James Way #403 20877 | | | | |
| 14. FATHER'S NAME FIRST Walter MIDDLE LAST Frazier | | | | | 15. MOTHER'S MAIDEN NAME FIRST Sara MIDDLE E. LAST Bennett | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 218-30-4087 | | 17. INFORMANT ADDRESS Evelyn R. Frazier same as 13e | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Lung
1629
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Atelectasis + Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/26 , 19 83 , to 12/31 , 19 83 , that (I) (we) last saw the deceased alive on Dec 31 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23a. SIGNATURE Boo K. Kim DEGREE | | | | | 23b. ADDRESS 8921 Shady Grove Ct, Gaithersburg MD | | | | | 22c. DATE SIGNED 12/31/83 | | | | |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT) Boo K. Kim | | | | | 23d. ADDRESS 8921 Shady Grove Ct, Gaithersburg MD | | | | | | | | | |
| 23e. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23f. DATE 1/4/84 | | 23g. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | | | 23h. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland | | | | | | |
| 24. FUNERAL DIRECTOR'S NAME Tyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike Rockville, Maryland 20852 | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 6 1984 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | | | | | |

24/51

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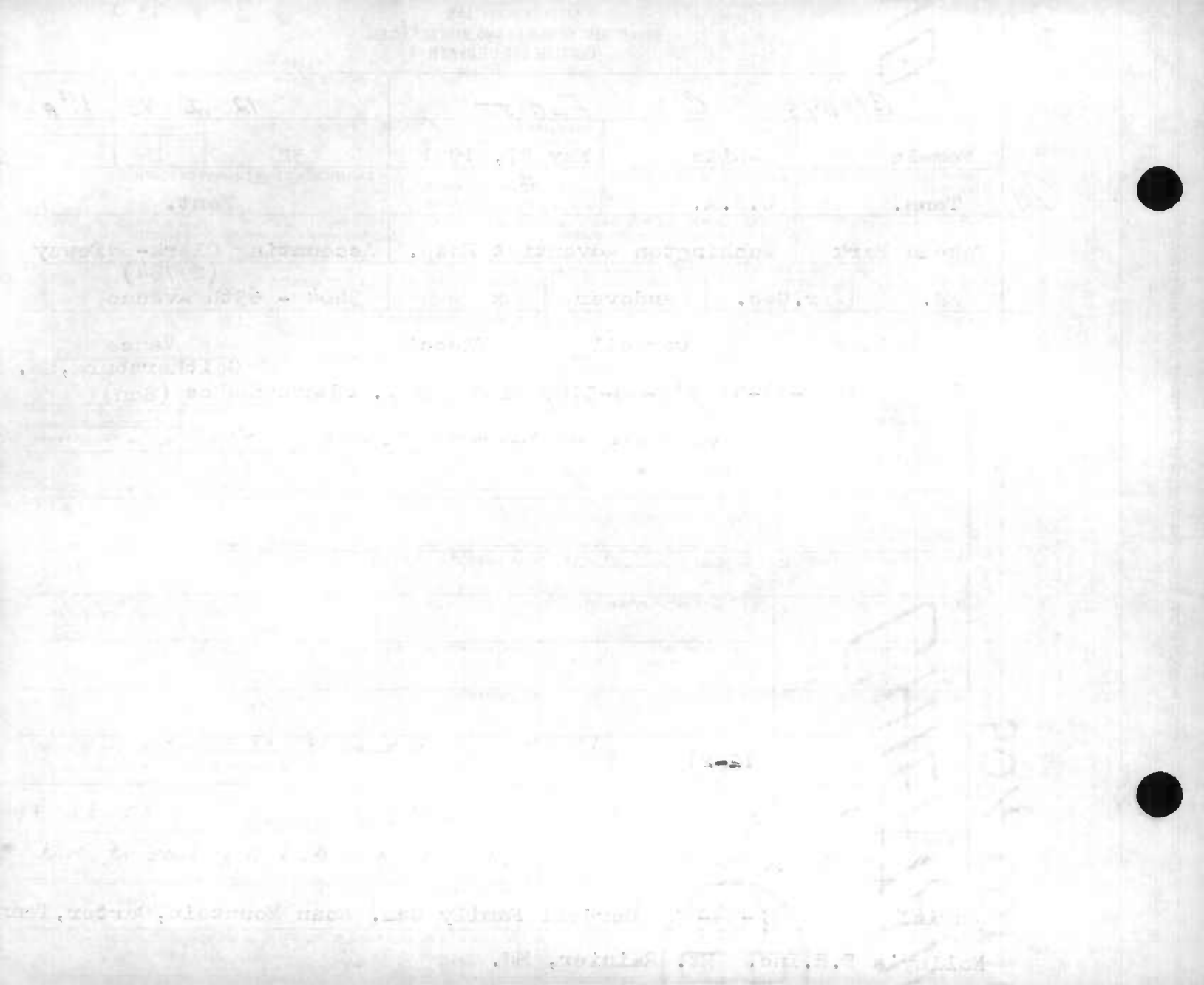
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or the medical officer of health must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | | | | | | |
|--|--|--|------------------------------|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) GLADYS C FUGITT | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 22 83 | | | | 2b. HOUR 1:10 A.M. | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 27, 1931 | | 6. AGE (IN YEARS LAST BIRTHDAY)
52 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Tenn. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Mont. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Accounting Clerk-Safeway | | | 12b. KIND OF BUSINESS OR INDUSTRY
(20784) | | |
| 13a. STATE
Md. | | 13b. COUNTY
Pr. Geo. | | 13c. CITY OR TOWN
Landover | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3804 - 65th Avenue | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dallas Cordell | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Flecci Vance | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO.
245-44-5167 | | 17. INFORMANT ADDRESS
Nicholas B. Pierouchakos (Son) | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenoma Metastatic carcinoma 19 months
1991
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
10-23-83
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NO <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-23-83 , to 12-21-83 , that (I) (we) lost saw the deceased alive on 12-21 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
M. Baig MD. | | | | | | DEGREE | | 22c. DATE SIGNED
12-22-83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. BAIG MD | | | | | | 22e. ADDRESS
3450 Rntmeal Rd, Laurel, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12-24-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Cordell Family Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Roan Mountain, Carter, Tenn | | | |
| 24. FUNERAL DIRECTOR
NAME
Nalley's F.H. Inc. Mt. Rainier, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 28 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carter | | | |

BP

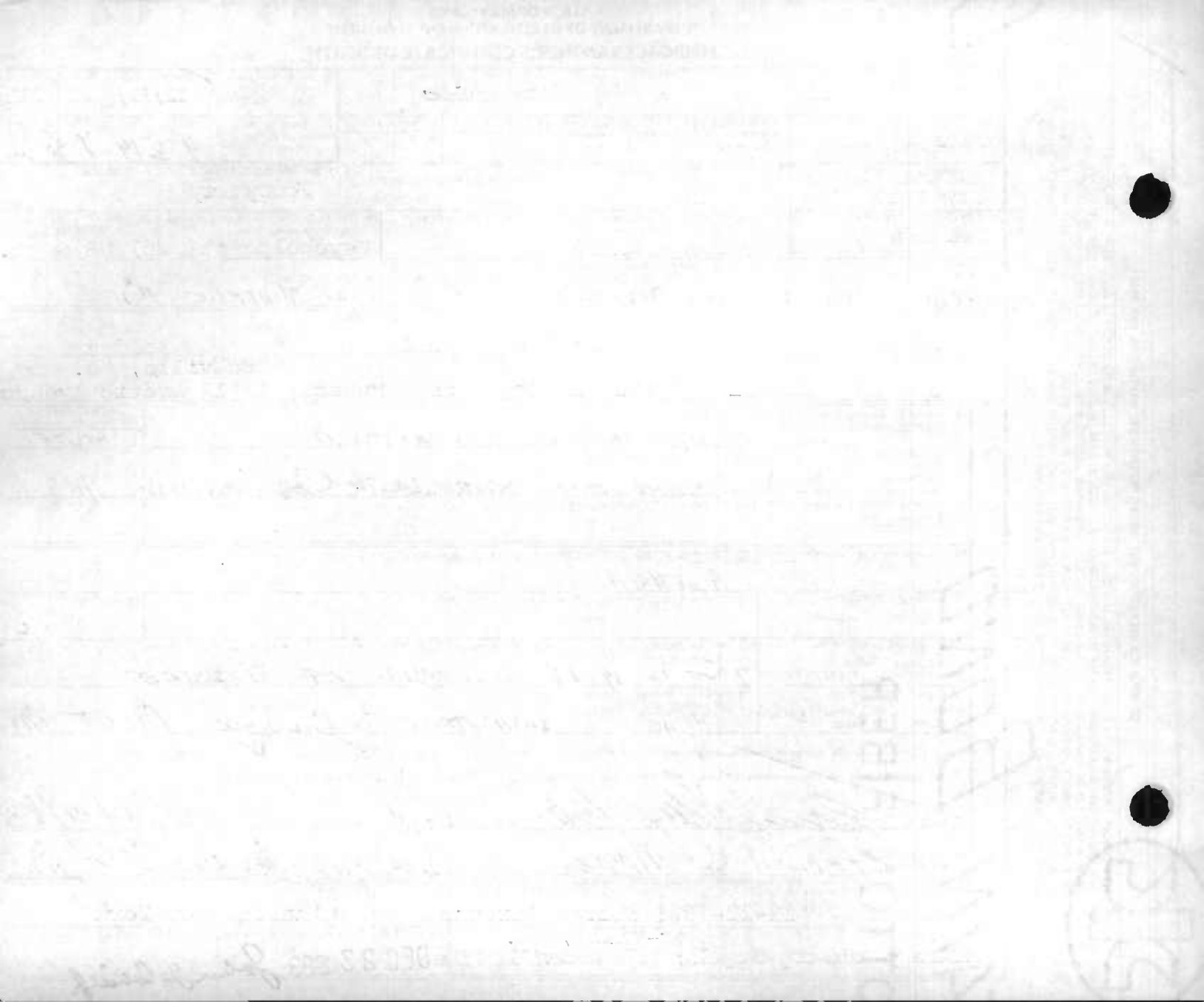


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|-------------------------|--|--|---|--|--|---|---|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Eli Frankfeldt | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
12/19/83 | | 2b. HOUR
832A | | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
4/19/10 | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
73 | IF UNDER 1 YR.
MONTHS DAYS
12 19 | IF UNDER 24 HRS.
HOURS MIN
58 32 | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12/19/83 | | 2d. HOUR
5832A | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Psychologist (Ret) | | 12b. KIND OF BUSINESS OR INDUSTRY
US Govt. | | | |
| 13a. STATE
MD | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6121 MONTROSE RD | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Michael Frankfeldt | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Feldman | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | |
| 16b. SOCIAL SECURITY NO.
117-09-6387A | | | | 17. INFORMANT
Carol Munach; 13813 Arctic Avenue | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
4100
(b) CORONARY ARTERIOSCLEROTIC CHANGES
DUE TO, OR AS A CONSEQUENCE OF
YVS
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ACUTE | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
ASTHMA | | | | | | | | | | | |
| 19a. DATE OF OPERATION
75 JAN 10 1983 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
COLLAPSED AT BEDSIDE | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
75 JAN 10 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
COLLAPSED AT BEDSIDE | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
6121 MONTROSE RD ROCKVILLE MONT MD | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
Francis C. Mayle | | TITLE (SPECIFY)
Dept | | M.D.
Dept | | MEDICAL EXAMINER
Dept | | DATE SIGNED
12/19/83 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Francis C. Mayle | | ADDRESS
820 Wisconsin Ave Bethesda MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-22-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Sharon Gardens | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Valhalla, New York | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 23 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | | | |

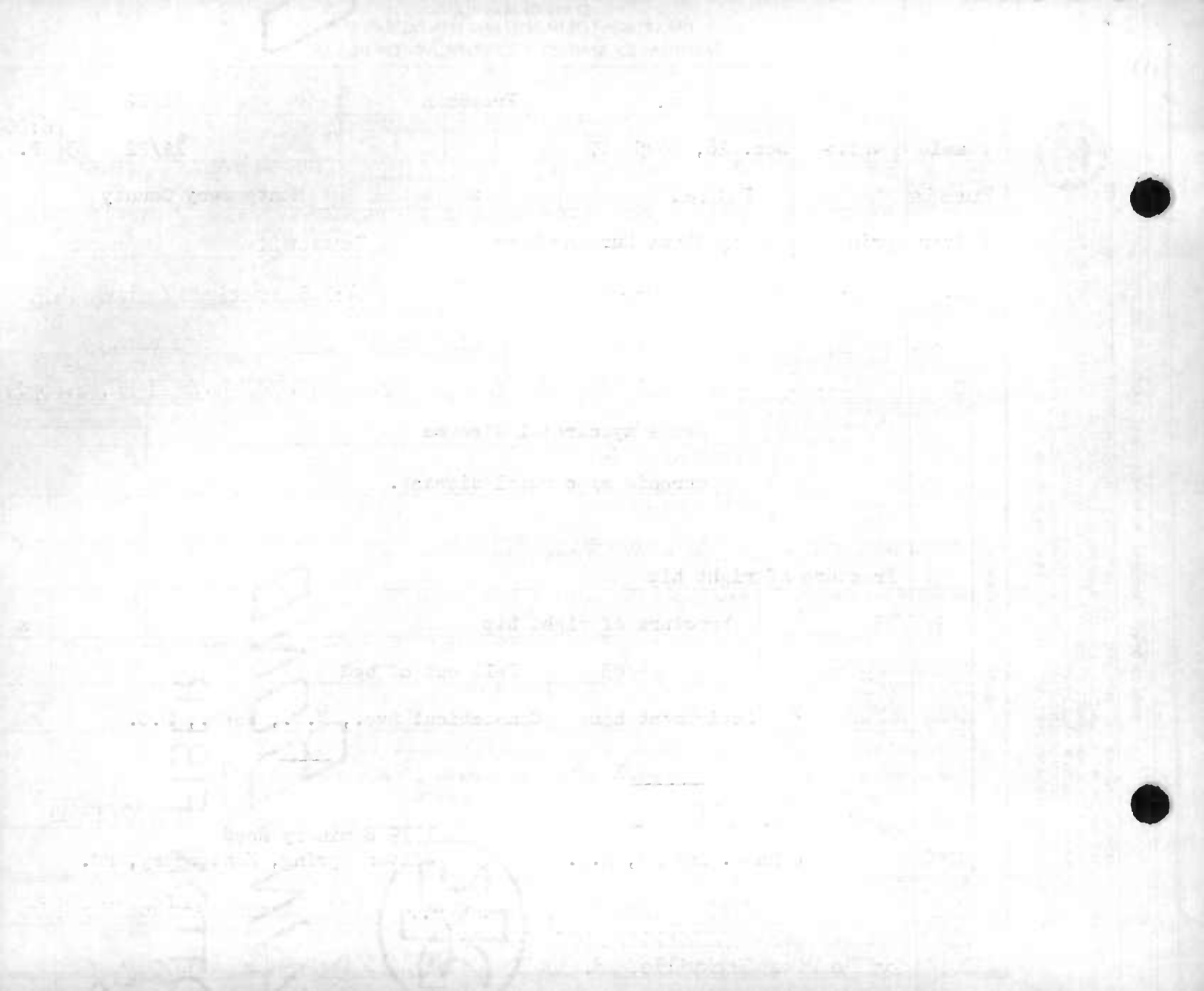
BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITALS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|-------------------------|---|---|---|--------------------------------|---|--|---|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Anna R. Freedman | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
12/22 19 83 | | 2b. HOUR
8:00 P.M. | | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 28, 1895 | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS.
HOURS MIN. | 7c. DATE PRONOUNCED DEAD
12/22 19 83 | | 7b. HOUR
P.M. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Chevy Chase Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a. STATE
D.C. | | 13b. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS
5420 Connecticut Avenue, N.W. | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Theodore Rubin | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Tillie Krinzman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
219-48-8716 | | 17. INFORMANT
ADDRESS
Loretta Freedman; 12625 Layhill Rd., S.Spg., Maryland 20906 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8842 IMMEDIATE CAUSE (a) Acute myocardial disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost
(b) chronic myocardial disease.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
Fracture of right hip | | | | | | | | | | | |
| 19a. DATE OF OPERATION
9/5/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
Fracture of right hip | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 9/4/83 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Fell out of bed | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Retirement home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Connecticut Ave., N.W., Wash., D.C. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John S. Rogers</i> | | M.D.
John S. Rogers, M.D. | | MEDICAL EXAMINER
ADDRESS
1919 Seminary Road Silver Spring, Montgomery, Md. | | DATE SIGNED 12/23/83 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/26/83 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Gdn. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church; Fairfax; Virginia | | | | | |
| 24. FUNERAL DIRECTOR
NAME
DANZANSKY-GOLDBERG MEMORIAL CHAPELS | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 27 1983 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Conick</i> | | | | | |
| 1170 Rockville Pike; Rockville, Md. 20852 | | | | | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Marguerite C Furlow | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 08 83 | | 2b. HOUR
A. 0635
M. |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
May 12, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Colorado | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Potomac | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert Campbell | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Gulick | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
577-18-4223 | | 17. INFORMANT
ADDRESS
Robert C. Furlow, Son, Same as item #13 | |

| | | | | | |
|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest</u>
4275
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>Chronic Bronchitis, COPD, Resp. Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Acute Myocardial Infarction, Severe Heart Disease</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Diabetes Mellitus, Hypertension, Arteriosclerosis, CHF.</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>83</u> , to <u>Dec 12</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>12/7</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>D. Shumaker MD</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/8/83</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>DOUGLAS T. SHUMAKER, MD</u> | | 22e. ADDRESS
<u>615 W. MONTGOMERY AVE
ROCKVILLE, MD 20850</u> | | | |

| | | | |
|---|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
Dec. 12, 1983 | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Maryland |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes,
P.A., Bethesda, Maryland | | 25a. DATE REC'D. BY REGISTRAR
DEC 14 1983 | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Carver</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained for the funeral home. Pages 1, 2, and 3 should be retained by the funeral home. Page 4 should be retained by the funeral home. Page 5 should be retained by the funeral home. Page 6 should be retained by the funeral home. Page 7 should be retained by the funeral home. Page 8 should be retained by the funeral home. Page 9 should be retained by the funeral home. Page 10 should be retained by the funeral home. Page 11 should be retained by the funeral home. Page 12 should be retained by the funeral home. Page 13 should be retained by the funeral home. Page 14 should be retained by the funeral home. Page 15 should be retained by the funeral home. Page 16 should be retained by the funeral home. Page 17 should be retained by the funeral home. Page 18 should be retained by the funeral home. Page 19 should be retained by the funeral home. Page 20 should be retained by the funeral home. Page 21 should be retained by the funeral home. Page 22 should be retained by the funeral home. Page 23 should be retained by the funeral home. Page 24 should be retained by the funeral home. Page 25 should be retained by the funeral home. Page 26 should be retained by the funeral home. Page 27 should be retained by the funeral home. Page 28 should be retained by the funeral home. Page 29 should be retained by the funeral home. Page 30 should be retained by the funeral home. Page 31 should be retained by the funeral home. Page 32 should be retained by the funeral home. Page 33 should be retained by the funeral home. Page 34 should be retained by the funeral home. Page 35 should be retained by the funeral home. Page 36 should be retained by the funeral home. Page 37 should be retained by the funeral home. Page 38 should be retained by the funeral home. Page 39 should be retained by the funeral home. Page 40 should be retained by the funeral home. Page 41 should be retained by the funeral home. Page 42 should be retained by the funeral home. Page 43 should be retained by the funeral home. Page 44 should be retained by the funeral home. Page 45 should be retained by the funeral home. Page 46 should be retained by the funeral home. Page 47 should be retained by the funeral home. Page 48 should be retained by the funeral home. Page 49 should be retained by the funeral home. Page 50 should be retained by the funeral home. Page 51 should be retained by the funeral home. Page 52 should be retained by the funeral home. Page 53 should be retained by the funeral home. Page 54 should be retained by the funeral home. Page 55 should be retained by the funeral home. Page 56 should be retained by the funeral home. Page 57 should be retained by the funeral home. Page 58 should be retained by the funeral home. Page 59 should be retained by the funeral home. Page 60 should be retained by the funeral home. Page 61 should be retained by the funeral home. Page 62 should be retained by the funeral home. Page 63 should be retained by the funeral home. Page 64 should be retained by the funeral home. Page 65 should be retained by the funeral home. Page 66 should be retained by the funeral home. Page 67 should be retained by the funeral home. Page 68 should be retained by the funeral home. Page 69 should be retained by the funeral home. Page 70 should be retained by the funeral home. Page 71 should be retained by the funeral home. Page 72 should be retained by the funeral home. Page 73 should be retained by the funeral home. Page 74 should be retained by the funeral home. Page 75 should be retained by the funeral home. Page 76 should be retained by the funeral home. Page 77 should be retained by the funeral home. Page 78 should be retained by the funeral home. Page 79 should be retained by the funeral home. Page 80 should be retained by the funeral home. Page 81 should be retained by the funeral home. Page 82 should be retained by the funeral home. Page 83 should be retained by the funeral home. Page 84 should be retained by the funeral home. Page 85 should be retained by the funeral home. Page 86 should be retained by the funeral home. Page 87 should be retained by the funeral home. Page 88 should be retained by the funeral home. Page 89 should be retained by the funeral home. Page 90 should be retained by the funeral home. Page 91 should be retained by the funeral home. Page 92 should be retained by the funeral home. Page 93 should be retained by the funeral home. Page 94 should be retained by the funeral home. Page 95 should be retained by the funeral home. Page 96 should be retained by the funeral home. Page 97 should be retained by the funeral home. Page 98 should be retained by the funeral home. Page 99 should be retained by the funeral home. Page 100 should be retained by the funeral home.

BP

RECEIVED
JAN 10 1910



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|---|--|--|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FRANCES G. GALHOLY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/17/83 | | 2b. HOUR
1:20 A.M. | |
| 3. SEX
Female | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 24, 1893 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
90 | | 7. BIRTHPLACE (STATE OR FOREIGN)
Michigan | | 8. CITIZEN OF WHAT COUNTRY?
United States | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN Hospital | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | 13a. STREET ADDRESS
4115 Aspen Lane. 20815 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William V. Grubbs | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Fannie Ayres | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | |
| 16b. SOCIAL SECURITY NO.
577 30 3230 | | 17. INFORMANT
Charles Westner (Son) same as #13 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
5845 Uremia
IMMEDIATE CAUSE (a) Uremia
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Tubular Necrosis
DUE TO, OR AS A CONSEQUENCE OF (c) "
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11(a). | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from July 1983 to date that (I) (we) lost saw the deceased alive on 12/16/83 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
Thos G. Mark | | 22c. DATE SIGNED
12/17/83 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thos G. Mark | | |
| 22e. ADDRESS
6116 Robinwood, Bethesda, MD 20817 | | 23a. BURIAL, CREMATION, REMOVAL
Burial | | | | |
| 23b. DATE
Dec. 19, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
Suitland, Maryland STATE | | |
| 24. FUNERAL DIRECTOR
NAME
Ives-Pearson Funeral Homes | | 24b. ADDRESS
Falls Church, VA 22046 | | 24c. DATE REC'D BY REGISTRAR
DEC 21 1983 | | |
| 24d. REGISTRAR'S SIGNATURE
John J. Connel | | | | | | |

MEDICAL CERTIFICATION

TO : DIRECTOR, FBI (100-374301)
FROM : SAC, NEW YORK (100-100000) (P)
SUBJECT: [Illegible]
RE: [Illegible]

[Illegible body text]

2025 COLLECTION

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ABE GALINSKY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 17, 1983 | | 2b. HOUR
9:17 A.M. | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 17, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Paper Ind. | | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 11447 Lockwood Dr. Apt. 104, 20904. | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Nathan Galinsky | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Etta Buff | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
233-10-6965 | | 17. INFORMANT
ADDRESS
Hilda F. Galinsky, Wife, Bethesda, Md. 20817 | | | | | |

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Gastrointestinal Hemorrhage APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Day | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Dissecting Abdominal Aortic Aneurysm 1 Day | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Generalized Arteriosclerotic Disease | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Hypertension, Organic Brain Syndrome, Azotemia | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from November 19, 73 to December 17, 83 , that (I) (we) last saw the deceased alive on Dec. 16, 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Martin C. Shargel M.D.
DECEASED ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
Dec. 17, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARTIN C. SHARGEL, M.D. | | | | 22e. ADDRESS
3720 Farragut Ave., Kensington, Md. 20895 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 19, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Judean Gardens Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Oney, Mont. Cty., Md. | |
| 24. FUNERAL DIRECTOR
NAME
W.W. CHAMBERS CO., 8655 Ga. Ave. SS, Md. 20910 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1983 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. Gough | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SARA E. GARCIA | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-5-83 | | | 2b. HOUR
9 A M | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 27 26 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Puerto Rico | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland Montgomery Silver Spring | | | | | | | |
| 14. FATHER'S NAME
Jose Cote | | | | 15. MOTHER'S MAIDEN NAME
Carmen Garcia | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(GIVE WAR OR DATES)
N/A | | 17. INFORMANT
ADDRESS
Sara E. Flores Daughter same as #13 | | | |

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

2503

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

Cardiac failure, hypertension

| | | | | | | | |
|------------------------|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
|------------------------|--|--|--|--|--|---|--|

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II) | | | |
|--|--|--|--|---|--|--|--|

| | | | | | |
|--|--|--|--|---|--|
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
|--|--|--|--|---|--|

22a. I certify that (I) (this hospital) attended the deceased from 10/27/83 19 to 12/5/83 19 that (I) (we) last saw the deceased alive on 12/4/83 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | | | |
|--|--|----------------|--|------------------------------|--|
| 23a. SIGNATURE
Miguel A. Rodriguez M.D. | | DEGREE
M.D. | | 23b. DATE SIGNED
12/05/83 | |
|--|--|----------------|--|------------------------------|--|

| | | | |
|--|--|--|--|
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT)
Miguel A. Rodriguez | | 23d. ADDRESS
831 University Blvd. Silver Spring | |
|--|--|--|--|

| | | | | | | | |
|---|--|---------------------------|--|--|--|--|--|
| 23e. BURIAL, CREMATION, REMOVAL
Burial | | 23f. DATE
Dec. 8, 1983 | | 23g. NAME OF CEMETERY OR CREMATORY
Municipal Cemetery | | 23h. LOCATION
CITY OR TOWN COUNTY STATE
Rio Piedras, Puerto Rico | |
|---|--|---------------------------|--|--|--|--|--|

| | | | | | |
|--|--|--|--|--|--|
| 24. FUNERAL DIRECTOR
NAME
Ives-Pearson Funeral Homes
Arlington, Va. 22201 | | 25a. DATE REC'D. BY REGISTRAR
DEC 12 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | |
|--|--|--|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARIE J. GASTON | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 - 18 - 83 | | | |
| 3. SEX 3c MALE | | | | 2b. HOUR 10:30 A.M. | | | |
| 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 4 04 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 yrs | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Haiti | | 7b. CITIZEN OF WHAT COUNTRY? Haiti | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Bernard | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estella Boncoeur | | 13e. STREET ADDRESS 2411 Lyttons ville Road 20914 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-94-9265 | | 17. INFORMANT Silver Spring, Maryland 20914
Alerte Antoine, son-in-law, 2411 Lyttons ville Rd | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
2030 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple myeloma
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11 , 19 83 , to 12/18 , 19 83 , that (we) lost saw the deceased alive on 12/18/83 , 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John Weiner MD | | | | DEGREE | | 22c. DATE SIGNED 12/19/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 22e. ADDRESS 4701 Randolph Rd Rockville, Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE Dec. 22, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE Port au Prince, Haiti | |
| 24. FUNERAL DIRECTOR McGuire Funeral Service, Inc. | | | | 25a. DATE REC'D. BY REGISTRAR DEC 21 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | |

RECEIVED

UNITED STATES DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C.

1918-1919

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|-------------------------|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Joseph H. Gawler | | 2a. DATE OF DEATH
MONTH 12 DAY 7 YEAR 83 | | 2b. HOUR 8:55 P.M. | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
June 14, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Funeral Director | | 12b. KIND OF BUSINESS OR INDUSTRY
Funeral | | 13. STREET ADDRESS
3320 Lowson Boulevard | |
| 14. FATHER'S NAME
FIRST Alfred MIDDLE B. LAST Gawler | | 15. MOTHER'S MAIDEN NAME
FIRST Sallie MIDDLE E. LAST Hager | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | |
| 16b. SOCIAL SECURITY NO.
577-09-5945 | | 17. INFORMANT
Joseph A. Gawler, Woodbury, Minnesota | | 18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Florida 13b. COUNTY Palm Beach 13c. CITY OR TOWN Delray Beach | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepato-renal failure
3030
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Congestive heart failure
(c) Chronic alcoholism | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days
1 year
2 years |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-4-83 , 19 83 , to 12-7 , 19 83 , that (I) (we) lost saw the deceased alive on 12-7 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
E. Morell | | 22c. DATE SIGNED
12/8/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Evett M. Morell | | 22e. ADDRESS
6000 EXECUTIVE BLVD, ROCKVILLE MD | |

| | | | |
|--|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
12/9/83 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | 23d. LOCATION
CITY OR TOWN Suitland, Maryland COUNTY STATE |
| 24. FUNERAL DIRECTOR
NAME Joseph Gawler's Sons, Inc.
ADDRESS 5130 Wisconsin Ave., N.W., Washington, D.C. | | 25a. DATE REC'D. BY REGISTRAR DEC 15 1983 REGISTRAR'S SIGNATURE John J. Connel | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CATHERINE DAVIS GESELL | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 22 1983 | | 2b. HOUR
12:05a |
| 3. SEX
FEMALE | 4. RACE
CAUCASTAN | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 1 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
IOWA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
OLNEY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY
H.E.W. |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
SILVER SPRING | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PAUL V. DAVIS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELSTIE LANDERS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
479-16-1375 | | 17. INFORMANT
DAUGHTER ADDRESS
12706 ROUTE 108 CLARKSVILLE, MD. 21029 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asystolic & hemodynamic shock
2001
DUE TO, OR AS A CONSEQUENCE OF
(b) perforated colon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) perforated typhlocolitis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
72 hrs
17 days
+ 6-8 wks | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION
12/14/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
perforated colon | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from 12/14 19 83 , to 12/22 19 83 , that (1) (we) lost saw the deceased alive on 12/22 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Francis J. Collins | | DEGREE
MD. | | 22c. DATE SIGNED
12/22/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. E. COLLINS MD. | | 22e. ADDRESS
3915 FERRARA DR. WHEATON, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
DEC. 23, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT. MD. | | 25a. DATE REC'D. BY REGISTRAR
DEC 28 1983 | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | 25b. REGISTRAR'S SIGNATURE
John J. Collins | | | |
| 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. | | | | | |

BP _____



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|---|---|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LUCIE JEANNE GIARD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 30, 1983 | | | 2b. HOUR
PM
7:39 | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
OCTOBER 6, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
FRANCE | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HENRI JEAN BAPTISTE MICHEL | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BAPTISTINE ROSA GAUTIER | | | 13e. STREET ADDRESS / ZIP CODE
602 W. EDMONSTON DR / 20852 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
577-84-1801 | | 17. INFORMANT
ADDRESS
LOUIS GIARD, 602 W. EDMONSTON DR, ROCKVILLE, MD. 20852 | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CHRONIC OBSTRUCTIVE PULMONARY DISEASE**

4960
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF
(b) **PNEUMONIA**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

PROBABLE INFECTION

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that the (this hospital) attended the deceased from DECEMBER 27 , 19 83 , to DECEMBER 30 , 19 83 , that the (we) lost
saw the deceased alive on DECEMBER 30 , 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above the (we) (did) not view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Leslie W. Hall</i> | | | | DEGREE
M.D. | | 22c. DATE SIGNED
31 DEC 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Leslie W. Hall, M.D., LT, MC, USNR | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD. 20814 | | | |

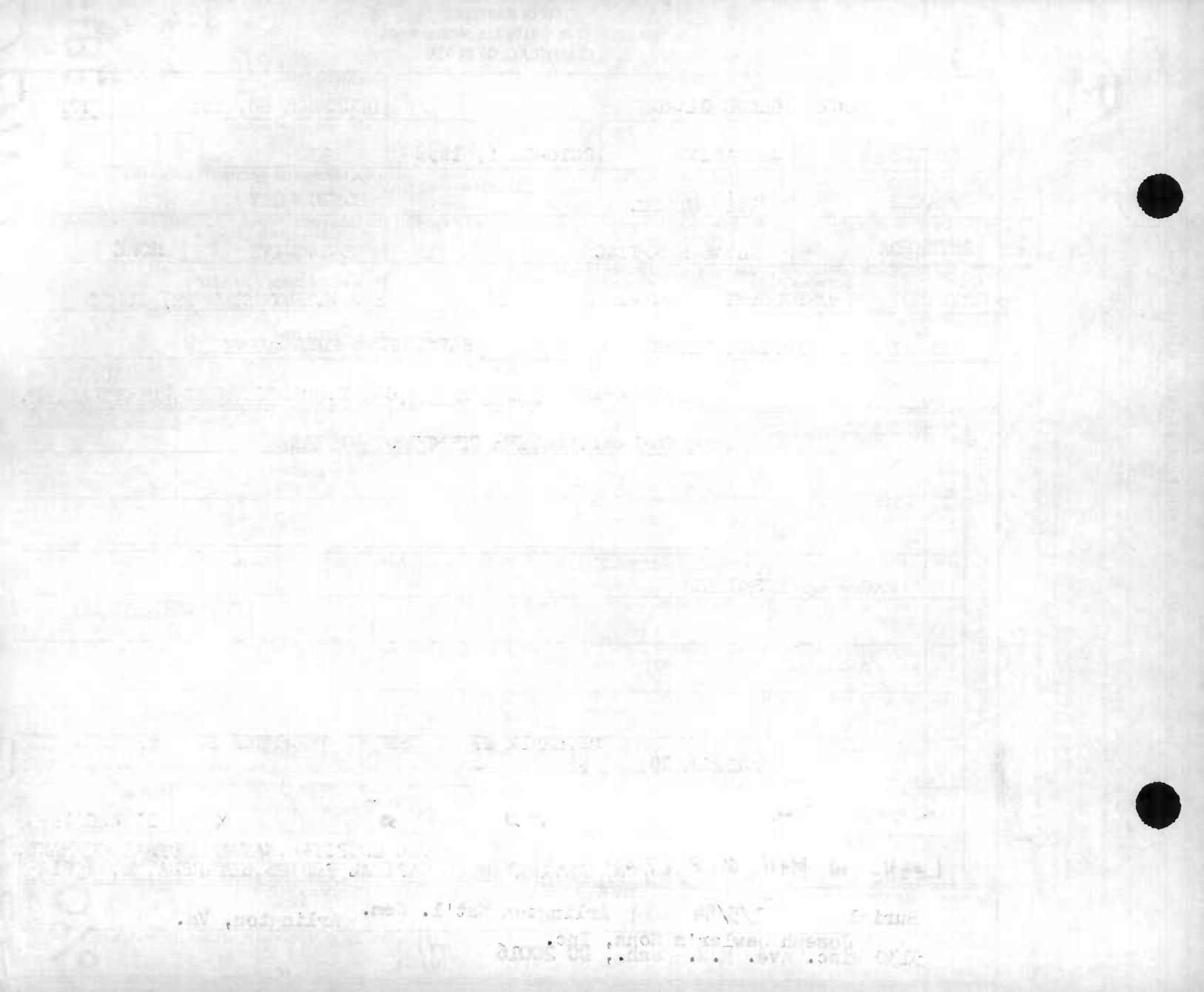
| | | | | | | | |
|---|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/5/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Va. | |
|---|--|----------------------------|--|--|--|---|--|

| | | | | | |
|--|--|---|--|--|--|
| 24. FUNERAL DIRECTOR
NAME
Joseph Gawler's Sons, Inc.
5130 Wisc. Ave. N.W. Wash., DC 20016 | | 25. DATE REC'D. BY REGISTRAR
JAN 4 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Connelley</i> | |
|--|--|---|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
TONI PATRICE GIDRON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 5 1983 | | 2b. HOUR
2:50 P_M |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
MONTH DAY YEAR
DECEMBER 3 1983 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. 2 | IF UNDER 1 YEAR
MONTHS DAYS
2 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | |
| 13a. STATE
VIRGINIA | | | 13b. COUNTY
FAIRFAX | 13c. CITY OR TOWN
RESTON | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 13e. STREET ADDRESS / ZIP CODE
11027 BEACON TREE LAKE DRIVE 99999 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
DAVID LEE GIDRON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SADIE MOZELLE LEE | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT
ADDRESS
SADIE M. LEE, 11027 BEACON TREE LAKE DRIVE, | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

7650

IMMEDIATE CAUSE (a) **EXTREME PREMATURITY**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

MEDICAL CERTIFICATION

| | | | |
|--|--|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 3 , 19 83 , to DECEMBER 5 , 19 83 , that (I) (we) last
saw the deceased alive on DECEMBER 5 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>Paul E. Farrell Jr.</i> | DEGREE
MD | 22c. DATE SIGNED
6 DEC 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PAUL E. FARRELL, LT, MC, USNR | ATTENDING <input type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>
PHYSICIAN DIRECTOR PHYSICIAN | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | |

| | | | |
|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION (REMOVAL)
(SPECIFY) | 23b. DATE
12-5-83 | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
National Naval Hosp | | 25a. DATE REC'D. BY REGISTRAR
DEC 8 1983 | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Carver</i> | |



1888-89

Northwestern

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) TORI NICHOLE GIDRON | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 9 1983 | | | 2b. HOUR
6:02 a.m. | | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
DECEMBER 3 1983 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
6 | | 7. IF UNDER 1 YEAR
IF UNDER 24 HRS
HOURS MIN.
6 | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 9b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | |
| 13a. STATE
VIRGINIA | | 13b. COUNTY
FAIRFAX | | 13c. CITY OR TOWN
RESTON | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
21229 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
DAVID LEE GIDRON | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SADIE MOZELLE LEE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT
ADDRESS
SADIE M. LEE, 11027 BEACON TREE LAKE DRIVE, | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

7650 IMMEDIATE CAUSE (a) **EXTREME PREMATURITY**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 3, 1983 , to DECEMBER 9, 1983 , that (I) (we) last
saw the deceased alive on DECEMBER 9, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>J. Montgomery, M.D.</i> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9 Dec 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. MONTGOMERY, LT, MC, USN | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | | |

| | | | | | | | |
|---|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Hosp/removal | | 23b. DATE
12/9/83 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME
National Naval Hospital, Bethesda, Md. | | | | 25. DATE REC'D. BY REGISTRAR DEC 16 1983 REGISTRAR'S SIGNATURE <i>John J. Carver</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1000

1000

1000

1000



1000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|---|---|---------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARGARET W. GLEESON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 6 83 | | 2b. HOUR
7:35 M | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 1 86 | | 6. AGE (IN YEARS LAST BIRTHDAY)
97 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ireland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
D.C. | | 13b. COUNTY
Washington | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
6100 32nd Street, N.W. 20015 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Michael Wolfe | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine Hartnett | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
220-54-1016 | |
| 17. INFORMANT
Niece | | 17. INFORMANT
Mary O'D. McMahon | | ADDRESS
5301 Westbard Circle Bethesda, Md. 20816 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4860

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 WEEKS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) the <u>hospital</u> attended the deceased from <u>FEB 5</u> , 19 <u>83</u> , to <u>DEC 6</u> , 19 <u>83</u> , that (I) was <u>last</u>
saw the deceased alive on <u>DEC 5</u> , 19 <u>83</u> , and that in (my) own <u>opinion</u> death occurred on the date and hour and from the causes stated
above, (I) was <u>did</u> (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Walter E. Goon</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6 DEC 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WALTER E. GOON MD | | | | 22e. ADDRESS
2309 SHOREFIELD RD WHEATON MD | | | |

| | | | | | | | |
|---|--|-----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 10, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins | | | | ADDRESS
500 University Blvd., W. Silver Spring, Md. | | 25. DATE REC'D BY REGISTRAR
DEC 13 1983 | |
| | | | | | | REGISTRAR'S SIGNATURE
<i>John J. Conner</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Winfield A GINGRICH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 8, 1983 | | 2b. HOUR
1:44p M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan., 4, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | 7b. CITIZEN OF WHAT COUNTRY?
U S A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital, Silver Spring | | 12a. USUAL OCCUPATION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Stock Broker | | 12b. KIND OF BUSINESS OR INDUSTRY
Brokerage Firm |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Chevy Chase | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
3603 Chevy Chase Lake Dr. #1 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George D GINGRICH | | | 15. MOTHER'S MAIDEN NAME
MIDDLE LAST
Elizabeth Rothfus | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
215-01-3526 | | 17. INFORMANT
ADDRESS
William G. Gingrich RFD 2 Williams Way Durham NH 03824 | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary ArrestAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Immediate

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

Coronary Heart Disease**Unknown**

DUE TO, OR AS A CONSEQUENCE OF

Generalized Arteriosclerosis**Unknown**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

Cerebral Hemorrhage Prostate Cancer, metastatic

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☒YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

22a. I certify that (I) (this hospital) attended the deceased from **December 19 79**, to **December 8 1983**, that (I) (we) lost
saw the deceased alive on **December 8 1983**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

Thomas C. Havell, MD**4201 Cathedral Av NW Wash., DC 20016**23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN COUNTY STATE**Cremation****DEC. 11, 83****Cedar Hill Crematory****Suitland****Maryland**

24. FUNERAL HOME OR OTHER PERSON TO WHOM BODY WAS DELIVERED

25. DATE REC'D. BY REGISTRAR

25a. REGISTRAR'S SIGNATURE

Joseph Gawler's Sons, Inc.
5130 Wisc. Av NW Wash., DC 20016

DEC 15 1983**Joan J. Conner**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Thomas C. McVey, MD
451 Constitution Ave NW, Wash., DC 20001

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
 STATE
 REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MIRIAM GOLDRING | | | 2a. DATE OF DEATH
MONTH 12 DAY 1 YEAR 83 | | | 2b. HOUR
7:47 ^{AM} | | | |
| 3. SEX
Female | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 7 DAY 15 YEAR 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
POLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
13113 Marigold Lane (20906) | |
| 14. FATHER'S NAME
FIRST Nathan MIDDLE WEISBERG LAST WEISBERG | | | 15. MOTHER'S MAIDEN NAME
FIRST Esther MIDDLE Schwartzberg LAST Schwartzberg | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO.
430-54-7929 | | | 17. INFORMANT
ADDRESS Maryland 20906
Samuel Goldring; 13113 Marigold Lane; Silver Sp | | | | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BLAST CANCER
1749
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 YEARS |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/1 83 to 12/1 83 , that (I) (we) last saw the deceased alive on 12/1 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
MARJORIE A. VITH MD | | | | DEGREE | | 22c. DATE SIGNED
12/2/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARJORIE A. VITH | | | | 22e. ADDRESS
106 Irving St NW Washington, DC 20010 | | | |

| | | | | | | | |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
12/4/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Judean Memorial Gdns. | | 23d. LOCATION
CITY OR TOWN Olney; Montgomery; Maryland COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS 1170 Rockville Pike; Rockville, Maryland 20852 | | | | 25a. DATE REG'D. BY REGISTRAR DEC 5 1983 REGISTRAR'S SIGNATURE John J. Carver | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CHIEF

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

| | | | | | | | |
|---|--|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>VICENTA D. GOMEZ</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>12 / 20 / 83</i> | | | 2b. HOUR
<i>10 A_M</i> | |
| 3. SEX
<i>FEMALE</i> | | 4. RACE
<i>HISPANIC</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>11 17 28</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>55</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Nicaragua</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>Nicaraguan</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Takoma Park</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Washington Adventist Hospital</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Homemaker</i> | |
| 12b. KIND OF BUSINESS OR INDUSTRY
<i>Own Home</i> | | 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Silver Spring</i> | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
<i>1703 East-West Hy 20910</i> | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Carlos nmn Gomez</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Maria nm Bermudez</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>577-06-7923</i> | | 17. INFORMANT
ADDRESS
<i>1730 East-West Hy 20910</i>
<i>Maria L. Bustamante Silver Spring Md.</i> | | | |

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Renal, hepatic failure</i>
<i>4860</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bilateral lobar pneumonia</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Abdominal aortic aneurysm, Ca 7-posterior</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<i>malnourished, fatty liver, emphysema, carcinoma</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/18/83</i> 19 to <i>12/20/83</i> that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Miguel A. Rodriguez</i> | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12/20/83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>MIGUEL A. RODRIGUEZ</i> | | 22e. ADDRESS
<i>831 University Blvd. S. Spring</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>Dec 25, 1983</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Granada Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Granada Nicaragua</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>W. W. Chambers Co</i> | | 8655 Georgia Ave
<i>Silver Spring, Md 20910</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 23 1983</i> | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Conish</i> | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 only.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|--|---|----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Agnes P. Goodlin | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 20 83 | | 2b. HOUR
1230 PM | | |
| 3 SEX
Female | | 4 RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 17, 1907 | | 6 AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS HOURS MIN.
76 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10 CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
2982 Glenora Lane 20850 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
Oscar E. Peterson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ellen Matilda Pearson | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES
No | |
| 16b. SOCIAL SECURITY NO
214 70 3873 | | 17. INFORMANT
Daughter | | ADDRESS
805 Hurley Ave. Rockville, Maryland | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrhythmia secondary to
4140
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Atherosclerotic Cardiomyopathy.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1981 , 19 12/20 , to 12/20 , 19 83 , that (I) (we) last saw the deceased alive on 12/20 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Susan Withrow MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/20/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Susan Withrow | | 22e. ADDRESS
15 E Deer Park, Ga. Kensington, MD 20877 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial Entombment | | 23b. DATE
Dec. 22, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Maryland | |
| 24 FUNERAL DIRECTOR
NAME
ROBERT A. PUMPHREY FUNERAL HOMES, PA., ROCKVILLE, MARYLAND | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1983 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. Lohr | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the death certificate. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Catherine D. Gorman</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>12/23/83</i> | | 2b. HOUR
<i>10:12 M</i> |
| 3. SEX
<i>Female</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>FEB. 20, 1915</i> | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>68</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Washington, D.C.</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery County</i> MD. | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>St. Joseph's Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>ANALYST</i> | | 12b. KIND OF BUSINESS
INDUSTRY
<i>AGENCY
DEFENSE SUPPLY</i> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY CITY OR TOWN
<i>MARYLAND MONTGOMERY SILVER SPRING</i> | | | 13b. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>JAMES LEON DAWSON</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>MARY BRADSHAW</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>579-01-5383</i> | | 17. INFORMANT
ADDRESS
<i>JAMES A. GORMAN SAME AS # 13 (HUSBAND)</i> | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i>
<i>7100</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 weeks</i> |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *Pulmonary embolus, pneumonia, renal failure, diabetic ketoacidosis*

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>September 77</i> to <i>December 23, 1983</i> , that (I) (we) last saw the deceased above, (I) (we) signed <i>Dec. 23, 1983</i> , and that (my) (our) opinion of death occurred on the date and hour and from the causes stated. | | | |
| 22b. SIGNATURE
<i>Martin C. Shargel</i> M.D. | | 22c. DATE SIGNED
<i>12/23/83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>MARTIN C. SHARGEL</i> | | 22e. ADDRESS
<i>3720 FARLACUT AVE.
KENILWORTH, MD - 20895</i> | |

| | | | |
|--|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>BURIAL</i> | 23b. DATE
<i>12/27/83</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>GATE OF HEAVEN CEMETERY</i> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>SILVER SPRING MARYLAND</i> |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>FRANCIS J. COLLINS</i>
<i>500 UNIVERSITY BLVD. W. SILVER SPRING, MD. 20901</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 28 1983</i> | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Lomick</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



Handwritten notes and a table on lined paper. The table has several columns and rows, with some cells containing numbers and others containing text. The handwriting is cursive and somewhat faded.

Below the table, there are several lines of handwritten text. The first line appears to be a heading or a title, followed by several lines of descriptive text. The handwriting is consistent with the notes above the table.

At the bottom of the page, there is a section with more handwritten text. This section includes what looks like a signature or a name, followed by some dates and possibly a reference number. The handwriting is still cursive and somewhat difficult to read.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | |
|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Graeves. | | 20. DATE OF DEATH
MONTH DAY YEAR
12-19-83 | | 21. HOUR
1:35 P M |
| 1. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
5-01-97 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 yrs |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(IF OTHER THAN MOST OF WORKING LIFE)
Ret. Govt. Mary Dept. | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE ADDRESS BEFORE ADMISSION)
Maryland | | 13b. COUNTY
Montg. | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FULLER'S NAME
(FIRST MIDDLE LAST)
Louis B. Graeves | | 15. MOTHER'S MAIDEN NAME
(FIRST MIDDLE LAST)
Rose Mary Fidler | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, GIVE WAR OR DATES)
YES | | 16b. SOCIAL SECURITY NO.
215-46-2984 | | 17. INFORMANT
ADDRESS
Marguerite H. Graeves (17e) |

18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c.)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Acute left lower lobe pneumonia**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

48 hrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Arteriosclerotic vascular disease - Advanced Rheumatoid arthritis

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from JULY 1970 to 12/19 1983 , that (1) (we) lost
saw the deceased alive on 12/19 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (1) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
James R. Coleman MD. | DEGREE | 22c. DATE SIGNED
12/19/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES R. COLEMAN MD | 22e. ADDRESS
9241 COLUMBIA BLVD
SILVER SPRING, MARYLAND 20910. | | |

| | | | |
|--|---------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | 23b. DATE
Dec 23-1983 | 23c. NAME OF CEMETERY OR CREMATORY
Greenwood | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Md. CO. MD. |
| 24. FUNERAL DIRECTOR
William Walters | | | |

11-10-82 1:32

10-10-82 1:32

10-10-82 1:32

10-10-82 1:32

10-10-82 1:32

10-10-82 1:32

10-10-82 1:32

10-10-82 1:32

10-10-82 1:32

10-10-82 1:32

10-10-82 1:32

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

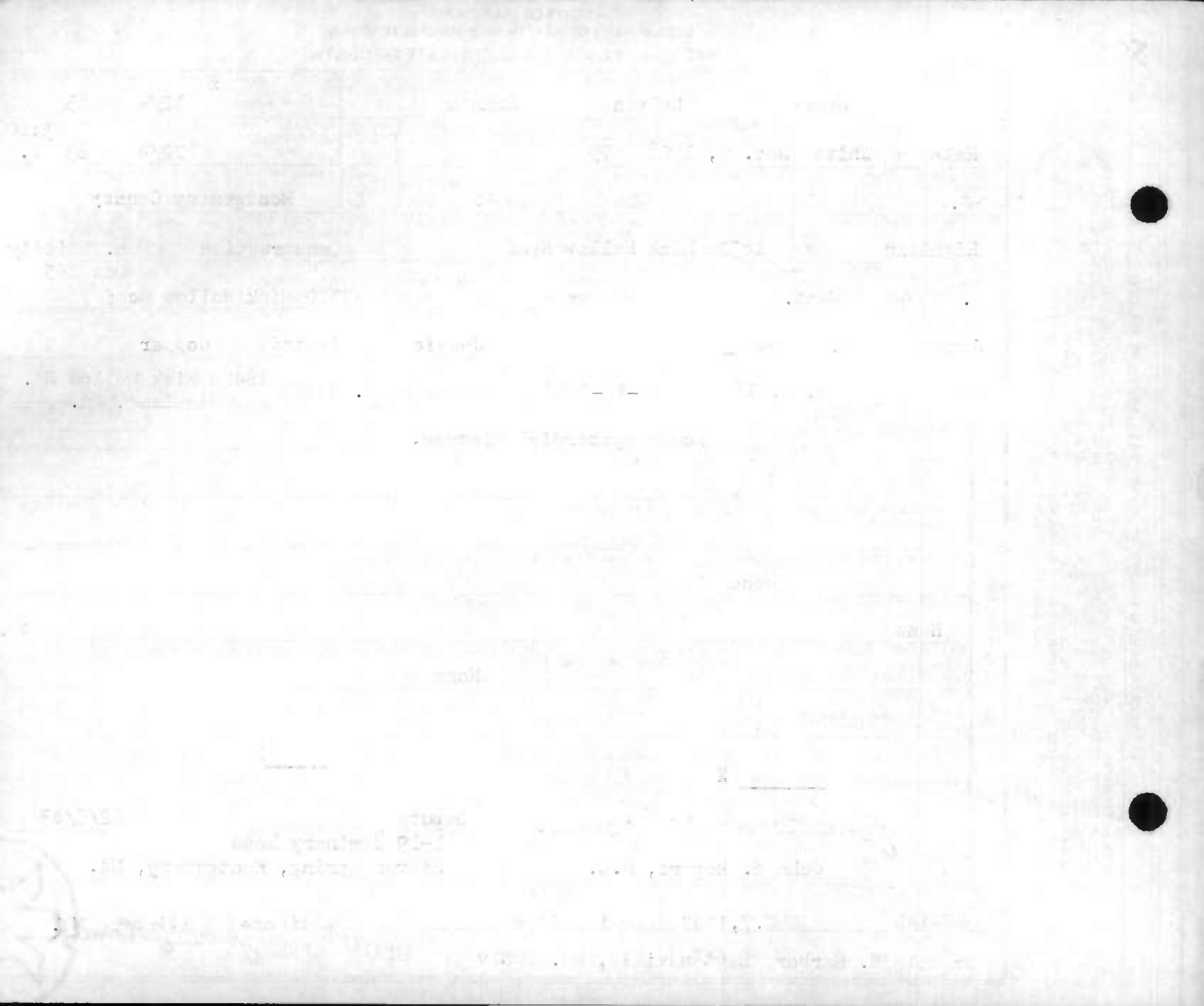
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|------------------|--|---------------------------------------|---|--------------------------------|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
James Melvin Graham | | | 2a. DATE KNOWN OF DEATH
12/4 19 83 | | | 2b. HOUR
5:00 P.M. | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
Nov. 9, 1908 | 6. AGE (IN YEARS)
75 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7c. DATE PRONOUNCED DEAD
12/4 19 83 | | |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH
Highland | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
18320 Mink Hollow Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Construction | | 12b. KIND OF BUSINESS OR INDUSTRY
Pub. Utility |
| 13a. STATE
Md. 20860 | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Sandy Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James M. Graham | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jessie Virginia Copper | | 13e. STREET ADDRESS
20860 Box 265
18320 Mink Hollow Road | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
W. W. II 217-10-9074 | | 17. INFORMANT
Katherine E. Beall | | ADDRESS
18400 Mink Hollow Rd.
Highland, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u>
4291
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
None | | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
None | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
<i>John S. Rogers</i> | | TITLE (SPECIFY)
Deputy MEDICAL EXAMINER | | | | DATE SIGNED
12/5/83 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
John S. Rogers, M.D. | | ADDRESS
1919 Seminary Road
Silver Spring, Montgomery, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
DEC. 7, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Baltimore | | |
| 24. FUNERAL DIRECTOR
NAME
Francis H. Barber | | | | ADDRESS
Laytonsville, Md. 20879 | | 25a. DATE REC'D. BY REGISTRAR
DEC 9 1983 | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

| | | | | | | | | |
|--|--|--|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mary Lee Grasley | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 9 83 | | | 2b. HOUR
4:40 AM | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 14 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Michigan | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(PLEASE WORK OR MOST REMARKABLE WORKING LIFE)
Dental Tech. | | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Dr. L. Toomey | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13a. COUNTY Montgomery 13a. CITY OR TOWN Silver Spring | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1608 Woodwell Road, 20906 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Nicholas Christie | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jeanette Gewont | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
ADDRESS
Robert J. Grasley-husband-(same as 13e) | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
1991 IMMEDIATE CAUSE (a) METASTATIC CA of Brain
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/14/83 to 12/19/83, that (I) (we) lost saw the deceased alive on 12/14/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
ALLEN B. COHEN | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/19/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS
18111 PRINCE PHILLIP OLNEY, MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 12, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Montgomery Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi Funeral Home | | 11800 N.H. Ave.,
Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Canfield | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at



10/10/57

10/10/57

10/10/57

10/10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH - 16 50M 4/83
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
CATHERINE ALICE GREELEY | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
DEC 23 83 | | 2b. HOUR
6:34P M | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
NOV 22 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
PR GEORGES | | 13c. CITY OR TOWN
BOWIE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
12709 NORTH CLIFF ROAD 20715 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
EDWARD MICHAEL CROWLEY | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ALICE MARIE GUNNING | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
186169889 | | 17. INFORMANT ADDRESS
GEORGE R. GREELEY 12709 N. CLIFF RD. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
7855 IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 15 DECEMBER 19 83 to 23 DECEMBER 19 83 , that (I) (we) lost saw the deceased alive on 23 DECEMBER 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Kennedy</i> | | | | DEGREE | | | | 22c. DATE SIGNED
12/23/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KENNETH LEE LCDR MC USNR | | | | 22e. ADDRESS
NAVAL HOSPITAL NAVAL MEDICAL COMMAND NAT. CAP. REG. BETHESDA MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK ONE)
Burial | | 23b. DATE
12-28-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, 20814 Virginia | | | | | |
| 24. FUNERAL DIRECTOR
NAME <i>Beall</i> ADDRESS
Beall Funeral Home, Bowie, Maryland 20815 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 27 1983 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Carick</i> | | | |

IREM

HOWARD

1941

10%

[Faint, mostly illegible text and markings covering the page, including what appears to be a table or ledger structure with multiple columns and rows.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
THEODORE ROOSEVELT GREENE
THEODORE R. GREENE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 12 9 83 | | | 2b. HOUR
1020 P.M. | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 30, 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY)
51 51 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired/Postal Service | | 12b. KIND OF BUSINESS OR INDUSTRY
Govt. | |
| 13a. STATE
Maryland | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Upper Marlboro | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
17130 Fairway View Lane | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Vattell Nathaniel Greene | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Bell Epps | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes/Army | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1953/1955 | | 17. INFORMANT
17130 Fairway View Lane
Gwendolyn Parker Greene (wife) | | 17b. ADDRESS
Maryland | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

2387 IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

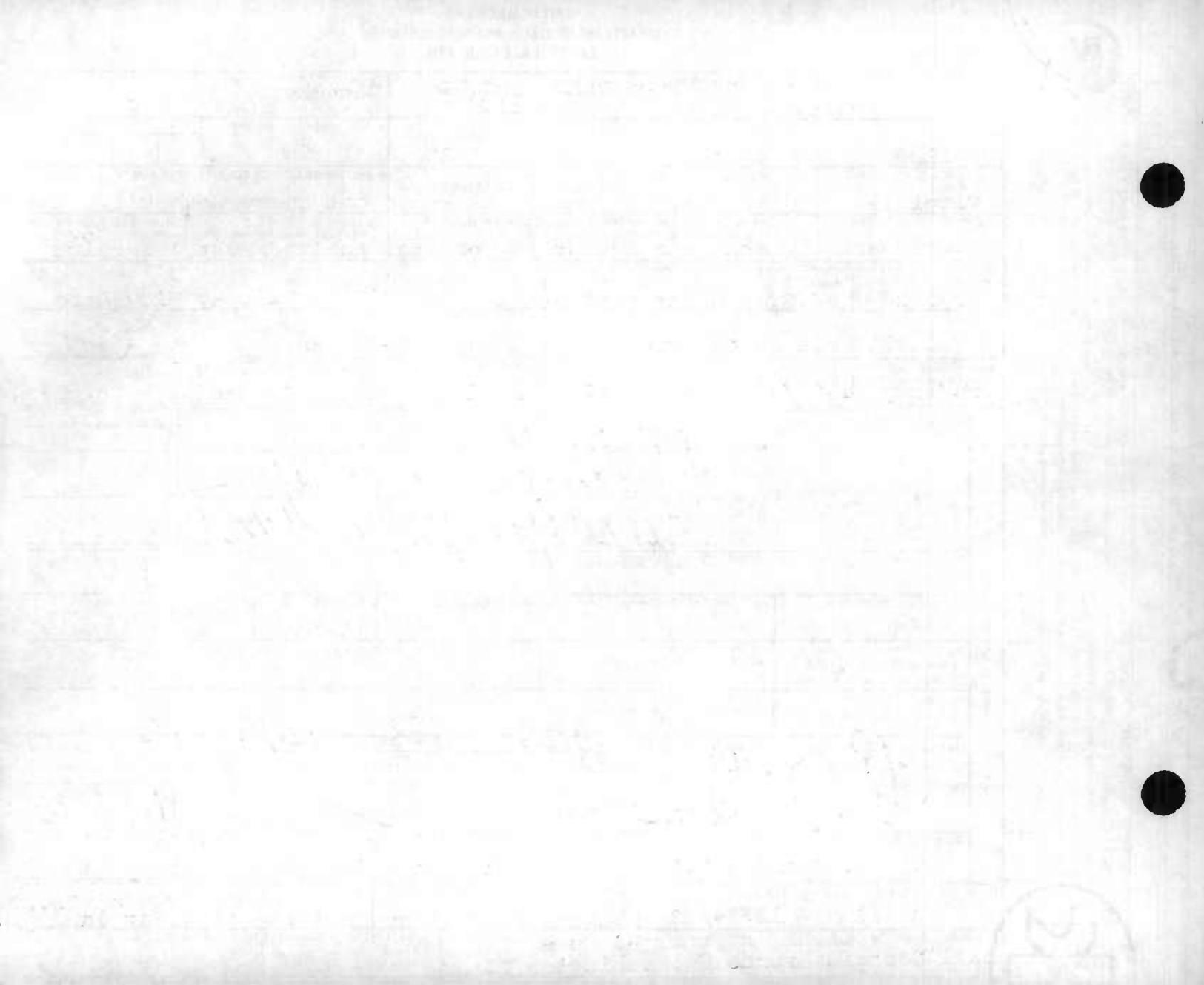
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/25 83, to 12/9 83, that (I) (we) lost saw the deceased alive and above the deceased (did) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Lewis H. Dennis | | | | DEGREE | | 22c. DATE SIGNED
12/10/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Lewis H. Dennis, M.D. | | | | 22e. ADDRESS
Silver Spring, Maryland 20903
831 University Blvd. East | | | |

| | | | | | | | |
|--|--|-----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/14/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Lakemont Cemetery | | 23d. LOCATION
CITY OR TOWN
Anne Arundel Co. Davidsonville, Maryland | |
| 24. FUNERAL DIRECTOR
NAME
LATNEY's Funeral Home
3831 Georgia Avenue, NW; Washington, DC | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. C... | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|--|---|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) LYCURGUS M. GRIFFITH | | | 2a. DATE OF DEATH
MONTH DAY YEAR 12/24/83 | | | 2b. HOUR
6:35 AM | |
| 3. SEX
M | 4. RACE
Cauc | 5. DATE OF BIRTH
MONTH DAY YEAR
04 25 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Collingswood Nursing Home | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY
Amer. Home Prods. | |
| 13a. STATE
Md. | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lycurgus Matthews Griffith, Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Malcha Wayman Riggs | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
577-09-7303 | | 17. INFORMANT
Clarice Griffith Gaithersburg, Md. 20878 | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
IMMED |
| 3320
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) ASPIRATION PNEUMONIA | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) PARKINSON'S DISEASE | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 17 SEPT 81 to 24 DEC 83 , that (I) (we) last saw the deceased alive on 20 DEC 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Walter E. Goetz | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
24 DEC 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WALTER E. GOOZT MD | | | | 22e. ADDRESS
8309 SHOREFIELD RD WHEATON MD | | | |

| | | | | | | | |
|---|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
12/27/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Oak Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Gaithersburg Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Gartner Sandison F.H. 316 E. Diamond Ave., Gaithersburg, Md. 20877 | | | | | | | |



28/11/11 Mr. H. B. Hall

Dear Sir,

I have the pleasure to acknowledge the receipt of your letter of the 14th inst.

in relation to the matter of the purchase of the land in the State of Texas.

I am sorry to hear that you are unable to visit the land at this time.

I am, however, glad to hear that you are still interested in the matter.

I am, Sir, very respectfully,
Yours very truly,
J. B. Hall

JOHN B. HALL

U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Dorothy V. Grinder | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 7 83 | | 2b. HOUR
0252 A.M. |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
September 15, 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 | IF UNDER 1 YEAR
MONTHS DAYS
YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Seamstress | 12b. KIND OF BUSINESS OR INDUSTRY
Industrial | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Maryland | | | 13c. COUNTY
Montgomery | 13d. CITY OR TOWN
Germantown | 13e. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lee McClellan Wiles | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Effie C. Smith | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
219-30-6419 | | 17. INFORMANT
ADDRESS
Dale F. Grinder husband same as 13e | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Small intestinal infarction (Mesenteric artery thrombosis)
DUE TO, OR AS A CONSEQUENCE OF
(b) Diabetic Keto acidosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Septic shock | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
one day |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Diabetes, Hypertension**

| | | | |
|---|---|--|---|
| 19a. DATE OF OPERATION
Dec. 6, 1983 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Mesenteric Artery thrombosis | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 5, 1983 to Dec 7, 1983 , that (I) (we) lost
saw the deceased alive on Dec 6, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Kien-hwei Lee | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
Dec 7, '83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Lee, Kien-hwei (Franklin) | | 22e. ADDRESS
14960 Carryback Dr. Gaithersburg, MD 20878 | |

| | | | |
|--|-----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Dec. 10, 1983 | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Maryland |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey, P.A., Rockville, Maryland | | 25a. DATE REC'D. BY REGISTRAR
DEC 14 1983 | 25b. REGISTRAR'S SIGNATURE
Joan J. Connel |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | REG. NO. | | | | | |
|--|--|---|--|---|--|--|--|--|-----------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARY A HALEY | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/28/83 | | | | 2b. HOUR
145 PM | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 18, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY County MD | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Mgr. Christian Book Store | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
199 Rollins Avenue 20852 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James P. Mulhern | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nora T. Ginley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
189 03 6361A | | 17. INFORMANT Brother ADDRESS 9 Paca Place
Edward J. Mulhern Rockville, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-respiratory arrest
4310
DUE TO, OR AS A CONSEQUENCE OF,
(b) Massive cerebral hemorrhage
DUE TO, OR AS A CONSEQUENCE OF,
(c) Cerebral arteriosclerosis | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 hr
10 day
10 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Hypertension, Atrial Fibrillation, Ventric. Hypertrophy & CVD | | | | | | | | | | | |
| 19a. DATE OF OPERATION
12/28/83 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
809 Viers Mill Rd. Rockville, Maryland | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/28/83 to 12/28/83 , that (I) (we) lost
saw the deceased alive on 12/28/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | | | | 23b. DATE
Dec. 31, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate Of Heaven | | 23d. LOCATION
(CITY OR TOWN) COUNTY STATE
Silver Spring, Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
ROBERT A. PUMPHREY FUNERAL HOMES, P.A.
ROCKVILLE, MARYLAND | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 3 1984 | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | | | |

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DIRECTOR OF THE
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1-
FOR
STATE
REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|------------------|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Charles Eugene Hall | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
12 25 1983 | | | 2b. HOUR
M
9:55A | |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 26, 1943 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
40 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12 26 1983 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Boyd's | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
20035 Peachtree Road | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | 13b. COUNTY
Montg. | 13c. CITY OR TOWN
Barnesville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
22201 Beallsville Road 20838 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Albert Hall | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Smith | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
4 Monroe St
Albert Hall, Jr. (Brother) Rockville, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
3030 IMMEDIATE CAUSE (a) Acute ethanol intoxication
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
Thomas D. Smith, M.D. | | TITLE (SPECIFY)
County Chief | | | | DATE SIGNED
12/27/83 | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS
111 Penn St. Balto., MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-30-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Jerusalem Bapt. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Poolesville, Montg. Md. | |
| 24. FUNERAL DIRECTOR
NAME
George R. Snowden | | ADDRESS
246 N. Washington St.
Rockville, Md. 20850 | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Cunniff | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

RECEIVED

NOV 19 1954



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
William J. Hanrahan | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 20, 1983 | | | 2b. HOUR
1:40 PM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
November 29, 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Chicago | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2605 Spencer Road | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Sales | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2605 Spencer Road (20815) | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward V. Hanrahan | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Kathleen - Walsh | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes W.W.II | | | | 16b. SOCIAL SECURITY NO.
845-18-6041 | | 17. INFORMANT
ADDRESS
James Hanrahan 157 Edge Way Arnold, Maryland | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA (CENTRAL NERVOUS SYSTEM)</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>SQUAMOUS CARCINOMA OF LUNG</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 MONTH
9 MONTHS |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>July 22</u> , 19 <u>83</u> , to <u>December 20</u> , 19 <u>83</u> , that (1) (we) last saw the deceased alive on <u>December 16</u> , 19 <u>83</u> , and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Dr. Leonard Gold, M.D.</u>
DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
Dec/20/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Leonard Gold, M.D. | | | | 22e. ADDRESS
8630 Fenton St. Rm. 230 Silver Spring, Md. | | | |

| | | | | | | | |
|---|--|-------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
12-21-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Chambers Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Riverdale, Pr. George, Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Chambers Funeral Home Silver Spring, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 23 1983 | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Conner</u> | |

| No. | Name of Plant | Origin | Date of Collection | Collector |
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| 99 | ... | ... | ... | ... |
| 100 | ... | ... | ... | ... |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, REMAINING PAGES OF THIS CERTIFICATE SHOULD BE EXECUTED IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH PAGE 5, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

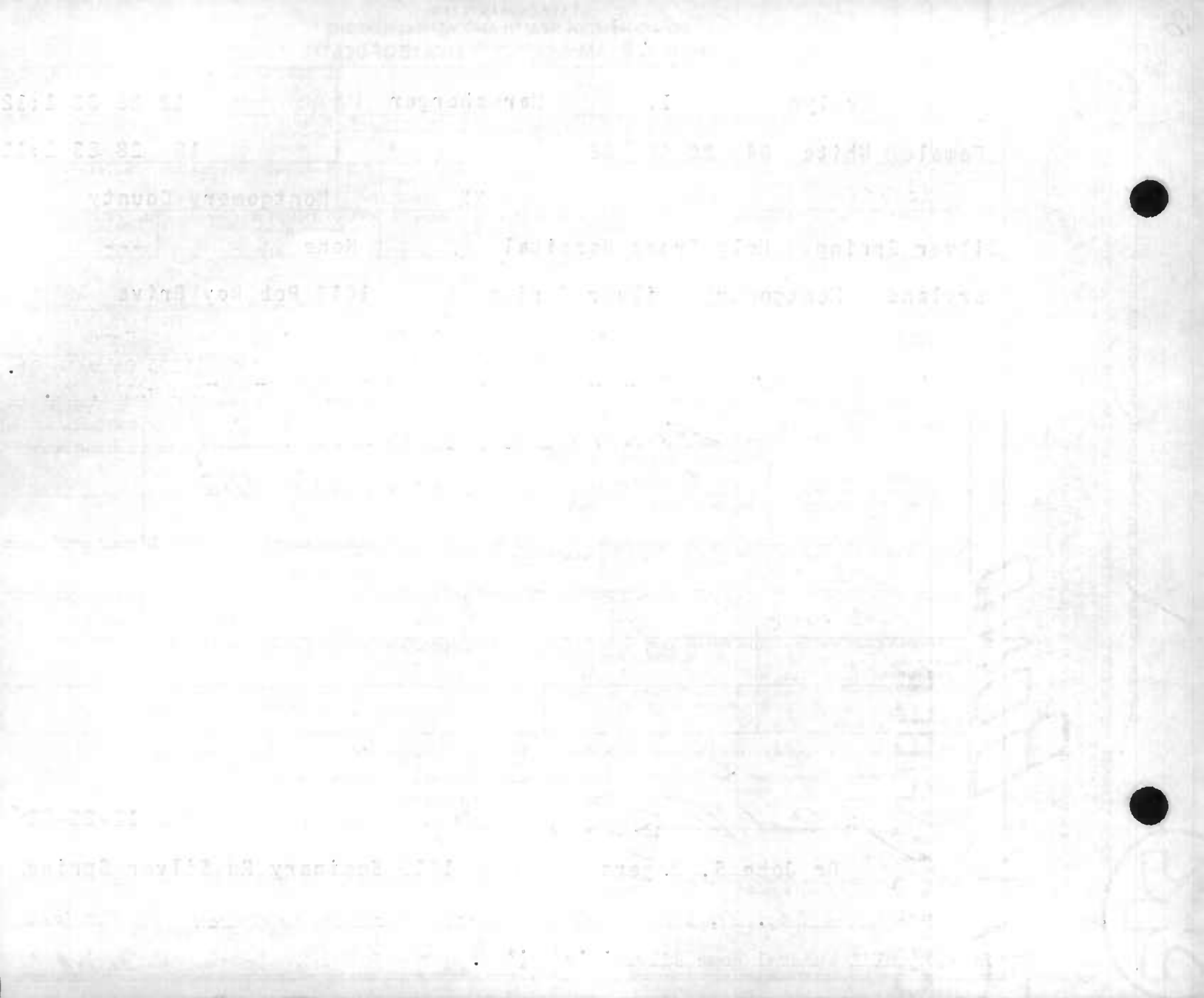
DHMH - 17
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|-------------------------|--|--|---|--|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Evelyn I. Harnsberger | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR
12 28 1983 | | | 2b. HOUR
1:12 | | | | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
04 20 95 | 6. AGE (IN YEARS)
LAST BIRTHDAY
88 YRS. | IF UNDER 1 YR.
MONTHS DAYS
00 00 | IF UNDER 24 HRS.
HOURS MIN.
00 00 | 2c. DATE PRONOUNCED DEAD
12 28 1983 | | | 2d. HOUR
1:12 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET ADDRESS
1013 Robroy Drive 20903 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Ivey | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minnie Mae Keys | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
N/A | | | | 16b. SOCIAL SECURITY NO.
578-09-3190 | |
| 17. INFORMANT
ADDRESS
Stephen Harnsberger-son | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Dis
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Chronic Myocardial Dis
DUE TO, OR AS A CONSEQUENCE OF
(c) 4291 | | | APPROXIMATE PERIOD BETWEEN ONSET AND DEATH
20853 | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
None | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
John S. Rogers | | | TITLE (SPECIFY)
Dr. | | | MEDICAL EXAMINER | | | DATE SIGNED 12-28-83 | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Dr. John S. Rogers | | | ADDRESS 1919 Seminary Rd Silver Spring | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Dec. 30, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
National Memorial Park Falls Church | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Virginia | | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi Funeral Home Silver Spring, Md. | | | ADDRESS
1800 N.H. Ave., Md. | | | 25. DATE REC'D. BY REGISTRAR
DEC 29 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | | | |



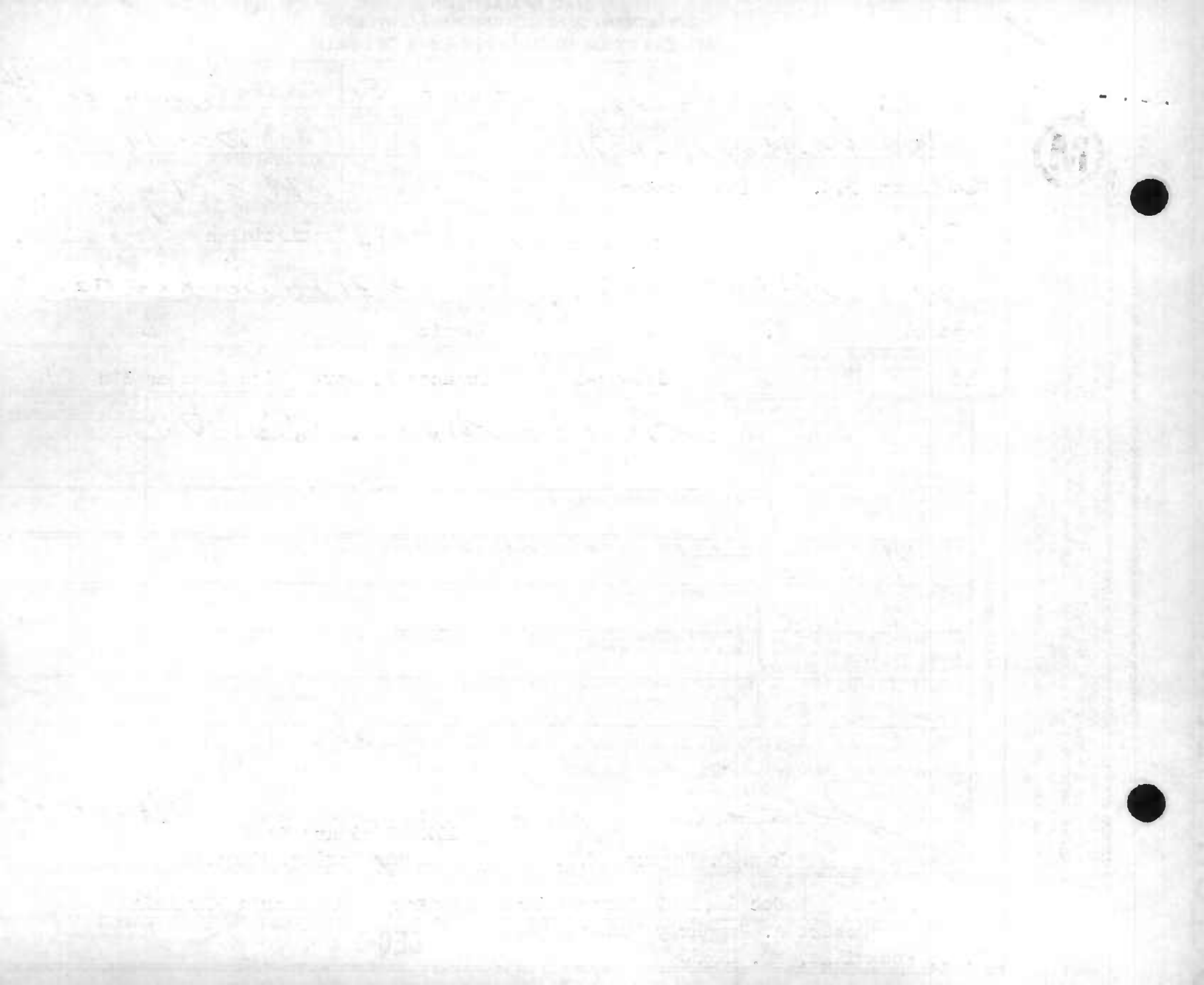
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXPLAIN THE REASON THEREFOR IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE MEDICAL EXAMINER. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. CALVERT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|---|--|-----------|--|--|--|-------------------|--|---|--|------------------|--|---|--|------------|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 20. DATE KNOWN
OF DEATH | | ESTI-
MATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Raymond S. | | Hart, Jr. | | | | | | Dec 14 1983 | | | | 12 | | PM | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE | | PRONOUNCED | | DEAD | | 2d. HOUR | |
| M | | W | | May 18 1971 | | 21 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Washington D.C. | | | | United States | | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | Montgomery | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | |
| Olney | | | | Monte General Hosp | | | | | | | | Statistician | | | | Keys Oil Co. | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | |
| MD | | | | Mont. | | | | Silver Spg | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | Zip: 20906
Beckenhart court | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Raymond | | | | S. Hart | | | | JESSIE | | | | Mason | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | | | | | |
| NO | | | | 577-07-3020 | | | | Frances A. Hart Wife Same as 13e | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).
PART 1 DEATH WAS CAUSED BY:
4291 IMMEDIATE CAUSE (a) Acute Myocardial bio
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | | | | | | | | | | | |
| None | | | | | | | | | | | | | | | | | | | |
| 19. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? | | | |
| None | | | | | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | | EXAMINER'S NAME
(TYPE OR PRINT) | | | | DATE
SIGNED | | | | MEDICAL EXAMINER | | | | | | | |
| John S. Rogers, M.D. | | | | 1979 Seminary Road | | | | Dec 14 1983 | | | | Silver Spring, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | |
| Cremation | | | | Dec 16, 1983 | | | | Metropolitan Crematory | | | | Alexandria Virginia | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Robert A. Pumphrey Funeral Homes,
P.A., Rockville, MD. 20850 | | | | DEC 19 1983 | | | | John S. Rogers | | | | | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

BH

1- FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|--|--|---|---------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CHRISTOS NMN HATZIERACLIS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 2, 1983 | | 2b. HOUR
7:15^P M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
JUNE 17, 1976 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GREECE | | 7b. CITIZEN OF WHAT COUNTRY?
GREECE | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE CLINICAL CENTER, NIH | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
student | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE
GREECE | | 13b. COUNTY
ATHENS | | 13c. CITY OR TOWN
ATHENS | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Epaminondas Hatzieraclis | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine Tsakiri | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
n/a | | 17. INFORMANT
ADDRESS
SAME AS CATHERINE HATZIERACLIS (MOTHER) ABOVE | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
7454
IMMEDIATE CAUSE (a) Ventriculo-septal defect
DUE TO, OR AS A CONSEQUENCE OF (b) Status-post transposition of the great vessels, 7 years corrected
DUE TO, OR AS A CONSEQUENCE OF (c) Intra-operative cardiac failure | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 years |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

| | | | | | |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION
Dec. 2, 1983 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Left A-V valve insufficiency | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 5, 1983 to December 2, 1983 , that I (we) last saw the deceased alive on December 2, 1983 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Dr. David J. Underhill | | DEGREE | | 22c. DATE SIGNED
12/3/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. DAVID J. UNDERHILL | | 22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH
CLINICAL CENTER, BETHESDA, MARYLAND 20205 | | | |

| | | | | | |
|---|--|------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-11-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Cemetery Analipsi Platia Neapoli, Praesus, Greece | |
| 23d. LOCATION
CITY OR TOWN
Analipsios #1 | | 23e. STATE
Greece | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Marshall's Funeral Home
4217 9th Street N.W.: Washington, D.C. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 12 1983 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON

CHIEF IN VA



DEC 1 1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|--|---|---|--|--|--|--|---------------------|
| 1- FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Mrs. Daisy Gladhill Haupt | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Nov. 27th, 1983. | | | | | 2b. HOUR
10:33am |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 2nd, 1882 | | 6. AGE (IN YEARS LAST BIRTHDAY)
101 years | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Myersville, MD. | | 7b. CITIZEN OF WHAT COUNTRY?
American | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Lutheran Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
at home... | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Kensington | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Daniel Gladhill | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Kinna | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | 16b. SOCIAL SECURITY NO.
214-10-2631 | | 17. INFORMANT
ADDRESS
Vivian M. Bachman 210 E. 3rd St. Fred | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>
4/40
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>arteriosclerotic Heart Disease</u>
5 yrs.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hrs. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
<u>Cerebrovascular insufficiency</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION
- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>1-5-77</u> , 19 <u>83</u> , to <u>11-27</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11-27</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Harold F. McCann, M.D.</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
11-27-83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>HAROLD F. MCCANN</u> | | | | 22e. ADDRESS
<u>3355-16th St. N.W. Wash, D.C. 20010</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 3, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Lutheran Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Middletown, Maryland | | | | |
| 24. FUNERAL DIRECTOR
NAME
The Hysong Company 1300 N St. N.W. Washington, D.C. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 12 1983 | | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>John J. Connel</u> | | | | | | | | | | |

BP



DEC 1 1963

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 3 6 7 9

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|------------------|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
DONNELL A. HAWKINS | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
12 9 1983 | | | 2b. HOUR
M
10:25 a | | |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 11, 1963 | 6. AGE (IN YEARS)
LAST BIRTHDAY
20 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12 9 1983 | 2d. HOUR
M
10:25 a | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hosp. (DOA) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Hawkins | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Adelle Briscoe | | | 13e. STREET ADDRESS
20877 17829 Laytonsville, Rd, #202 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
213-86-6196 | | 17. INFORMANT
ADDRESS
Adelle Hawkins (mother) 8105 Cross-over Ln, Rockville, Md. 20852 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cranio-cerebral trauma</u>
8147
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
8:50x 12-9- 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Pedestrian struck by truck. | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
18930 Laytonsville Rd., Gaithersburg, Mont. Co. Md. | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
12-10-83 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-14-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Brooke Grove Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Laytonsville, Montg. Md. | | |
| 24. FUNERAL DIRECTOR
NAME
George R. Snowden | | 246 N. Washington St.
Rockville, Md. 20850 | | 175a. DATE RECEIVED BY REGISTRAR
DEC 13 1983 | | | | |

DEC 13 1983

1974-1975

WIND
DOWN
1000-1000

1000-1000

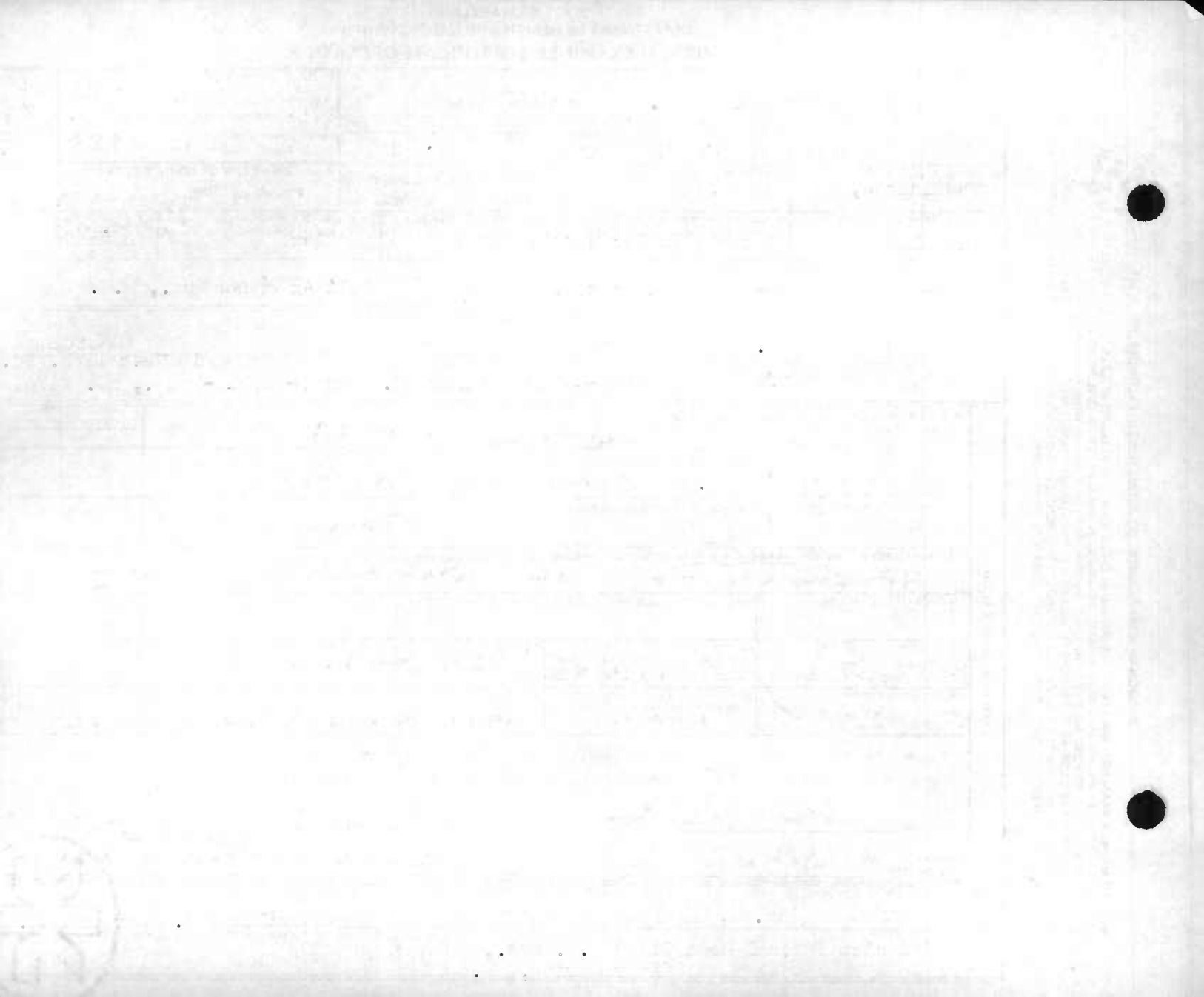
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ENCOUNTERED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|--|----------------------|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Beatrice C. Haxton | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 12 DAY 29 YEAR 83 | | 2b. HOUR 11:40 P M |
| 3. SEX F. | 4. RACE White | 5. DATE OF BIRTH
MONTH 4 DAY 17 YEAR 91 | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 92 YRS. | 7. IF UNDER 1 YR.
MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, DC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery | | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | 11. KIND OF BUSINESS
Dept. of Defense |
| 12. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE -- COUNTY -- | | 13b. CITY OR TOWN
Washington, DC | | 13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 14. FATHER'S NAME
FIRST Wallace MIDDLE K. LAST Haxton | | 15. MOTHER'S MAIDEN NAME
FIRST Hannah MIDDLE Goetting LAST Goetting | | 16. ADDRESS 10 West 13th. St. |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) N/A | | 17b. SOCIAL SECURITY NO.
579-40-1791A | | 17. INFORMANT
Richard I. Haxton-nephew-Fred., Md. 21701 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
4140
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary artery
DUE TO, OR AS A CONSEQUENCE OF
(c) Disease. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Fractured rib and atelectasis of Lung | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
2 P.M. 12 18 83 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Fell at Home |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | | 21f. LOCATION
STREET 4914 Arkansas ave CITY OR TOWN Wash. DC. COUNTY STATE |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | |
| ACTUAL SIGNATURE John Tamber | | TITLE (SPECIFY)
Deputy | | DATE SIGNED 12-30-83 |
| EXAMINER'S NAME
(TYPE OR PRINT) John Tamber | | ADDRESS 8218 WISCONSIN ave | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
Jan. 3, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
George Washington |
| 23d. LOCATION
CITY OR TOWN Hyattsville COUNTY Pr. Georges STATE Md. | | 24. FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md. | | |
| 25a. DATE REC'D. BY REGISTRAR
JAN 4 1984 | | 25b. REGISTRAR'S SIGNATURE
John S. Tamber | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please return carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
George ELDRIIDGE HAYDEN SR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
November 30, 1983 | | 2b. HOUR
7:45a M | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
January 17, 1919 | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital, Silver Spring | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
DEPT. STORE | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
11416 Sherrie Lane 20902 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE L. HAYDEN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
AGNES OLIVER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | 16b. SOCIAL SECURITY NO.
182-18-3483 | | 17. INFORMANT
ADDRESS
Duke Street 217
Leonardtown, Md. 20650 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
4140
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 mins. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
78 Nov 83 | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 22 1983, to Nov 83, that (I) (we) lost
saw the deceased alive on above, (I) (we) (did) (did not) with the body after death. | | | | | | |
| 22b. SIGNATURE
Howard S. Goldstein MD. | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
11-30-83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Howard S. Goldstein | | 22e. ADDRESS
4701 Randolph Rd Rockville Md 20852 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12-3-83 | | 23c. NAME OF CEMETERY OR CREMATORY
SACRED HEART | | 23d. LOCATION
CITY OR TOWN COUNTY
BUSHWOOD, ST. MARV'S, MARYLAND |
| 24. FUNERAL DIRECTOR
NAME
BRINSFIELD FUNERAL HOME | | LEONARDTOWN, MARYLAND
59 N. Washington St. | | 25a. DATE REC'D. BY REGISTRAR
DEC 7 1983 | | |
| 25b. REGISTRAR'S SIGNATURE
John E. Gault | | | | | | |



Harland Thompson 2101 Spring Lane
Silver Spring 2015 Cross Road, Silver Spring, Md.
Wife
White
January 11, 1949
November 20, 1963
1-423

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 3 6 8 2

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|-----------------------|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>William Hayco</i> | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
<i>Dec 4 1983</i> | | |
| 3. SEX
<i>M</i> | 4. RACE
<i>Blk</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>July 28 1966</i> | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
<i>17</i> | IF UNDER 1 YR.
MONTHS DAYS
<i>17</i> | IF UNDER 24 HRS.
HOURS MIN.
<i>17</i> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Georgia</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> | | 10. CITY OR TOWN OF DEATH
<i>Tak Park</i> | | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>West Advent Hosp</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
<i>Md</i> | | | | | |
| 13b. COUNTY
<i>Mont</i> | | 13c. CITY OR TOWN
<i>Tak Park</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
<i>20912 704 Fairview Ave</i> | | 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Tom Hayes</i> | | | |
| 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Lula Tate</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
<i>Yes</i> | | | |
| 16b. SOCIAL SECURITY NO.
<i>577-18-6641</i> | | 17. INFORMANT
ADDRESS
<i>John Hayes/3636 16th St. N. W., D. C.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute myocardial Dis.</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.
<i>None</i> | | | | | |
| 19a. DATE OF OPERATION
<i>None</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
<i>John J. Connel</i> | | TITLE (SPECIFY)
M.D. <i>Dep.</i> | | MEDICAL EXAMINER
DATE SIGNED <i>Dec 4, 1983</i> | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>12/8/83</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Harmony Memorial</i> | |
| 23d. LOCATION
CITY OR TOWN
<i>Landover</i> | | COUNTY
<i>Md.</i> | | STATE | |
| 24. FUNERAL DIRECTOR
<i>Sam Butler Inc. Funeral Home</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 6 1983</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Connel</i> | |
| 716 Kennedy St. N. W. D. C. | | | | | |



W
D
B
R
22814
C-11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

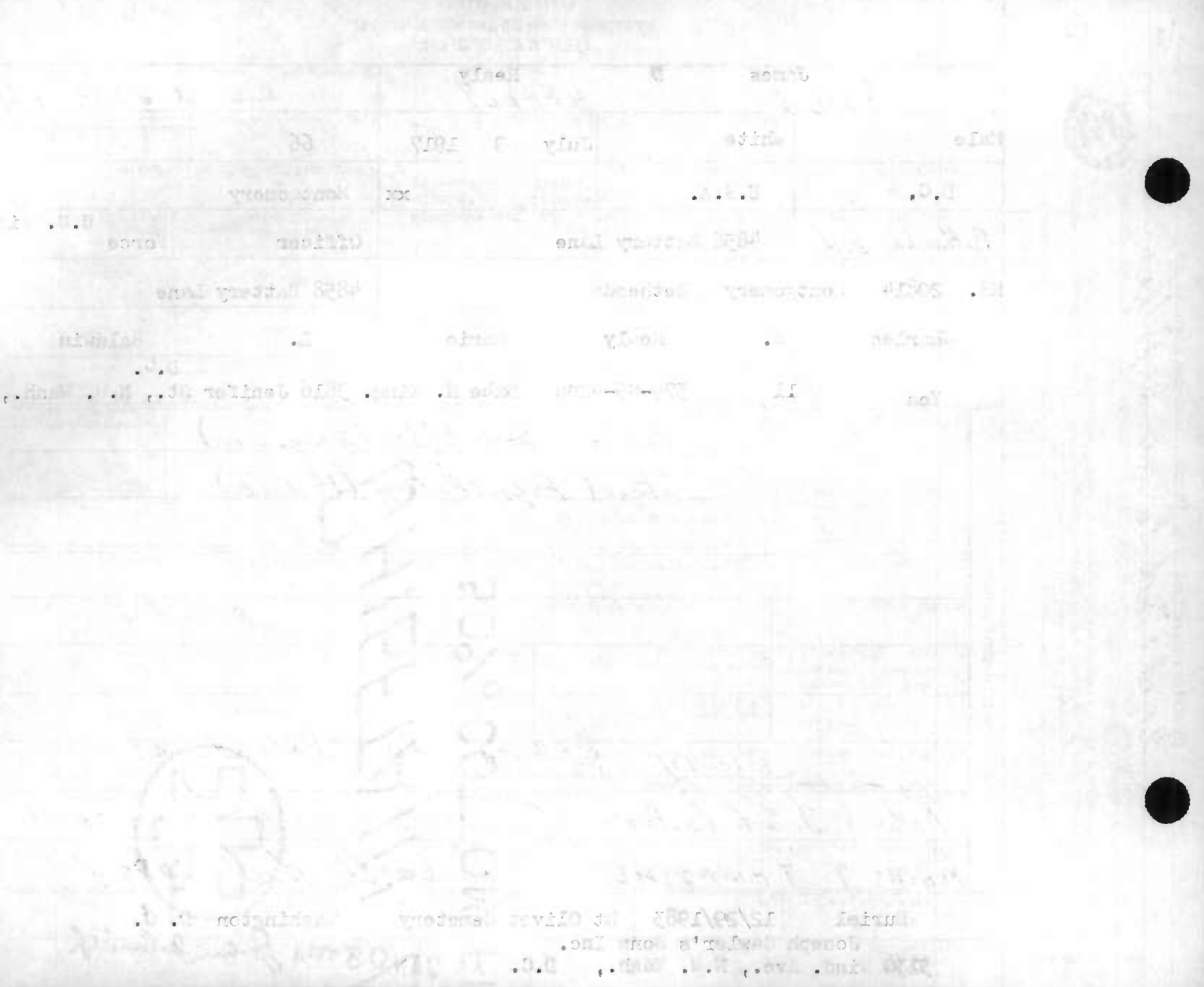
DHMH - 16 50M 4/83
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 1B shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Woodrow W. HAYZLETT | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-12-83 | | | 2b. HOUR
1:25 P.M. | | | |
| 3. SEX
Male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 16, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital, S/Spring | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Minister | | 12b. KIND OF BUSINESS OR INDUSTRY
Methodist Church | | | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lon G. Hayzlett | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julia Ann Fowler | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
Janie F. Hayzlett | | ADDRESS
Same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).
PART I. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) Acute myocardial infarction 1 hr
DUE TO, OR AS A CONSEQUENCE OF (b) Sudden coronary artery disease yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/12/83 to 12/12/83, that (I) (we) lost above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
ALAN I. KERMAIER, MD | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/12/83 | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | | | | 23b. DATE
Dec. 16 | | 23c. NAME OF CEMETERY OR CREMATORY
Columbia Gdns. Cemetery | | 23d. LOCATION
Arlington, Va. COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME
Ives-Pearson Funeral Homes
Arlington, Va. 22201 | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 20 1983 | | | | | 25b. REGISTRAR'S SIGNATURE
John J. Smith | |

— 32 —

1000 0 0 230



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Helen L. Hedrick | | | 2a. DATE OF DEATH
MONTH 12 DAY 22 YEAR 83 | | | 2b. HOUR
10:10 A.M. | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH 11 DAY 19 YEAR 96 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Kansas City Mo. | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Spring Grove | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Colonial Villa Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF MONTH PRECEDING LIFE)
Home Maker | | 12b. KIND OF BUSINESS OR INDUSTRY
- | |
| 13a. STATE
MD. | | 13b. COUNTY
Prince George | | 13c. CITY OR TOWN
Adelphi | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST Joseph MIDDLE Roman LAST Lopp | | 15. MOTHER'S MAIDEN NAME
FIRST Mary MIDDLE O'Toole LAST O'Toole | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
- | | 16b. SOCIAL SECURITY NO.
451-26-4594D | | 17. INFORMANT
Ellen May Hart (Daughter) | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory infection - dehydration
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis and
DUE TO, OR AS A CONSEQUENCE OF (c) aging process with arteriosclerosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
days - |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **heart disease**

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION
- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from February 71 , to Dec. 22 1983 , that (I) (we) last saw the deceased alive on Dec - 20 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Fred W. Brennwald | | | | DEGREE
MD | | 22c. DATE SIGNED
12.22.83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
F.W. BRENNWALD | | | | 22e. ADDRESS
831 University Blvd E. Silver Spring | | | |

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY
Georgetown Cemetery Hyattsville Md. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME
Takoma Funeral Home | | 25a. DATE REG'D. BY REGISTRAR
DEC. 30 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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424

6204 to the Great Lakes

421-22 10-12-1940 Mr. Mayfield (see page 10)

THE NATIONAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33086

| | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|--------------------------|--|---------------------|--|--------------------------|--|---|--|----------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | | | | | | | | | 2b. DATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE KNOWN OF DEATH | | | | | | | | | | 2b. DATE OF DEATH | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 1 YR. | | 7c. DATE PRONOUNCED DEAD | | 2b. DATE OF DEATH | | | |
| 16. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 17. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. NEVER MARRIED | | 10. WIDOWED | | 11. DIVORCED | | 12. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | | | | | | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 13. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 13f. STREET ADDRESS | | 13g. STREET ADDRESS | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 17. ADDRESS | | 17. ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: | | PART I DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) | | IMMEDIATE CAUSE (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| (b) | | (b) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| (c) | | (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | |
| 21a. EXTERNAL CAUSE WAS | | 21b. TIME OF INJURY | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 21f. LOCATION | | | |
| WHILE AT WORK NOT WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 21f. LOCATION | | | |
| 22a. I certify that I took charge of the remains described above, held on | | 22a. I certify that I took charge of the remains described above, held on | | | | | | | | | | 22b. I certify that I took charge of the remains described above, held on | | | |
| death resulted from: | | death resulted from: | | | | | | | | | | 22b. I certify that I took charge of the remains described above, held on | | | |
| Natural causes | | Natural causes | | | | | | | | | | 22b. I certify that I took charge of the remains described above, held on | | | |
| Accident | | Accident | | | | | | | | | | 22b. I certify that I took charge of the remains described above, held on | | | |
| Suicide | | Suicide | | | | | | | | | | 22b. I certify that I took charge of the remains described above, held on | | | |
| Homicide | | Homicide | | | | | | | | | | 22b. I certify that I took charge of the remains described above, held on | | | |
| Undetermined manner | | Undetermined manner | | | | | | | | | | 22b. I certify that I took charge of the remains described above, held on | | | |
| ACTUAL SIGNATURE | | ACTUAL SIGNATURE | | | | | | | | | | DATE SIGNED | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | EXAMINER'S NAME (TYPE OR PRINT) | | | | | | | | | | DATE SIGNED | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | 23b. DATE | | | |
| 23b. DATE | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION | | | |
| 23d. LOCATION | | 23d. LOCATION | | | | | | | | | | 23e. DATE REC'D. BY REGISTRAR | | | |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
SHIRLEY BOHRER HEFLIN | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 23, 1983 | | 2b. HOUR
7:40 A.M. |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
OCTOBER 21, 1920 | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ADMIN. ASST. | 12b. KIND OF BUSINESS OR INDUSTRY
C&P TELE.CO. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
KENSINGTON | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAY LOUIS BOHRER | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EDNA RYAN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
579-18-0810 | | 17. INFORMANT
ADDRESS
MARIE B. PATTERSON - COUSIN - KENSINGTON, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
4100
DUE TO, OR AS A CONSEQUENCE OF,
(b) Arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
None | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
None | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
_____ | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
_____ | | 21f. LOCATION
STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____ | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/22 19 83 , to present 19 _____, that (I) (we) lost
saw the deceased alive on 12/22 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
J.B. Umaha | | DEGREE
MD | | 22c. DATE SIGNED
12/23/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN B. UMAHA, M.D. | | 22e. ADDRESS
8805 CONN. AVENUE CHEVY CHASE, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/27/83 | | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL CEM | |
| 23d. LOCATION
CITY OR TOWN
ARLINGTON | | COUNTY
VIRGINIA | | STATE
VIRGINIA | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | ADDRESS
500 UNIVERSITY BLVD. W., SILVER SPRING, MD. | | 25. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DEC 28 1983 <i>John J. Umaha</i> | |

BP _____



| | | | | | |
|-----------------|--|-------------------------|-------------------|-----------------------------|-------|
| NO | JAN | LOUIS | BOHNER | EDNA | EVAN |
| 570-18-6810 | WHITE C. WATKINSON - COUSIN - KENNINGTON, DC | 4113 CLEMENSE ST. 20832 | | | |
| MARYLAND | MONTGOMERY | WASHINGTON | X | 3333 UNIVERSITY BLVD. # 308 | 20832 |
| STREET 37ING | HOLY CROSS HOSPITAL | ADMIN. ASST. | CAP TEL. CO. | | |
| WASHINGTON D.C. | U.S.A. | X | MONTGOMERY | | |
| FEMALE | CANASTA | OCTOBER 21, 1920 | 63 | | |
| SHIRLEY | BOHNER | HEATH | DECEMBER 23, 1943 | | |

JOHN B. UHARA, M.D.
 6205 COM. AVENUE CHEVY CHASE, DC.
 12/21/22
 ARKINGTON NATIONAL GEN ATTKINSON
 VIRGINIA
 FRANCIS J. COLLINS
 500 UNIVERSITY BLVD. ST. STREET 37ING DC.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

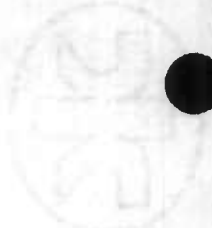
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FANNIE | | | LAST HEPNER | | 2a. DATE OF DEATH
MONTH 12 DAY 21 YEAR 1983 |
| 3. SEX
Female | | | 4. RACE
white | | 5. AGE (IN YEARS (LAST BIRTHDAY))
86 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
POLAND | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. DATE OF BIRTH
15, 1897 |
| 10. CITY OR TOWN OF DEATH
Bethesda md | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hosp | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY |
| 13a. STATE
md | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville |
| 14. FATHER'S NAME
FIRST HARRIS MIDDLE MUSHINSKY LAST MUSHINSKY | | | 15. MOTHER'S MAIDEN NAME
FIRST MIRIAM MIDDLE ETA LAST FISHER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO.
577-50-4195 | | 17. INFORMANT
HAROLD NUSSBAUM,
ADDRESS 7825 13th STREET, N. W. WASHINGTON, D. C. 20012 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
4140
DUE TO, OR AS A CONSEQUENCE OF (b) pulmonary Edema
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day
3 days
- |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Sigmoid volvulus, sepsis, bowel obstruction | | | | | |
| 19a. DATE OF OPERATION
12/15/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Repair of sigmoid volvulus | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/21/83 to 7/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Peter B. Sherer | | DEGREE MD | | 22c. DATE SIGNED
12/21/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Peter B. Sherer MD | | 22e. ADDRESS
3947 Ferrara Dr. Wheaton md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
12/22/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
BETH SHOLOM CONGREGATION | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
CAPITOL HEIGHTS, PR. GEO. MARYLAND | | 23e. DATE REC'D. BY REGISTRAR
DEC 27 1983 | | | |
| 24. FUNERAL DIRECTOR
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W. WASHINGTON, D. C. | | | | | |

WATSON 271 110

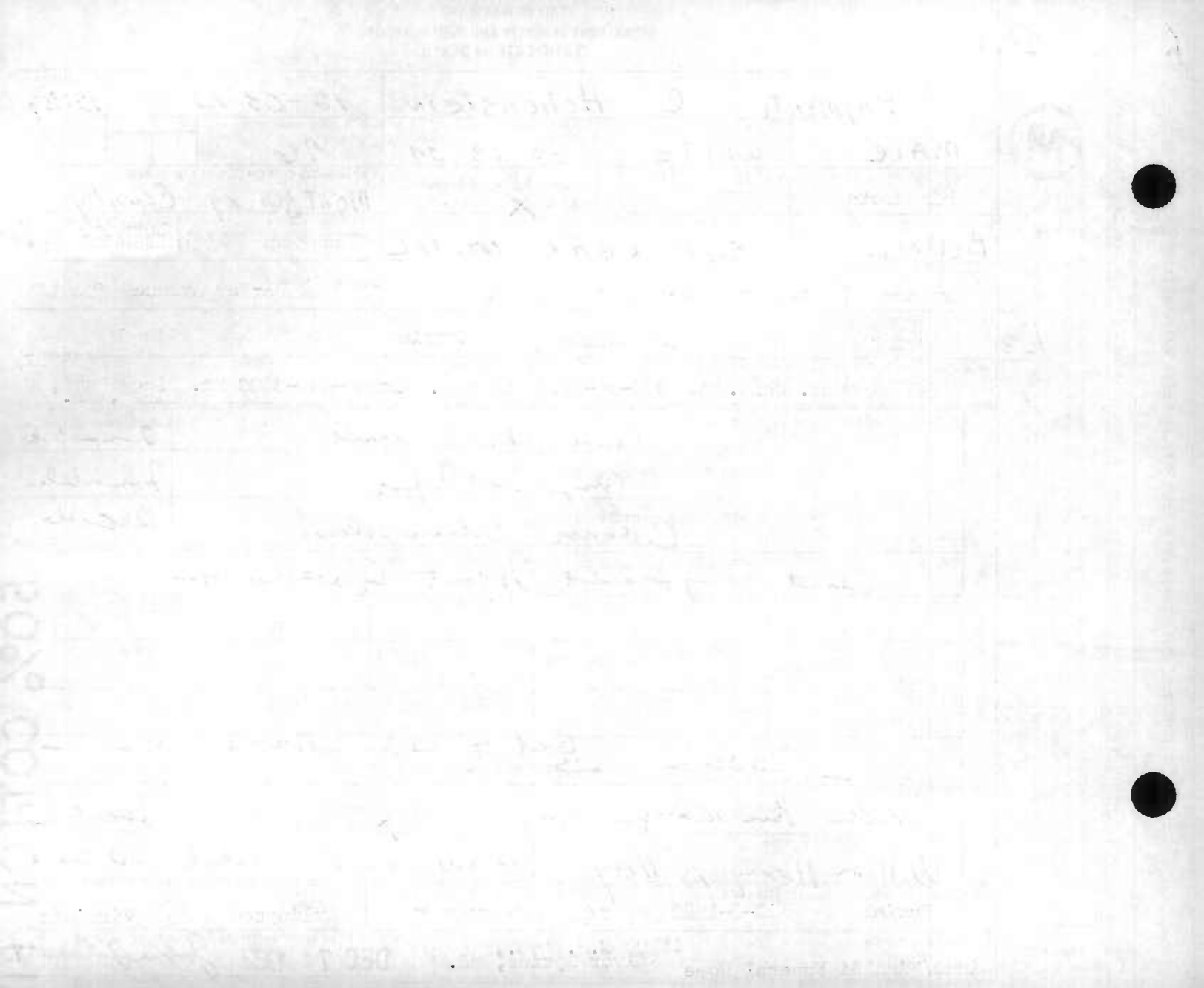


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|--|--|--|--|---|--|-----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) RAYMOND C Hohenstein | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-03-83 | | | | 2b. HOUR 12:35 PM | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 08 13 09 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHUREBAN Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clergyman | | 12b. KIND OF BUSINESS OR Lutheran Church Missouri Synod | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION): | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 5200 Camberley Avenue (20814) | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Bethesda | | 15. MOTHER'S MAIDEN NAME Harriet Weyl^{1st} | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST August Hohenstein | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriet Weyl^{1st} | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | |
| 16b. SOCIAL SECURITY NO. Ret. Chap. UNN 562-54-0721 | | | | 17. INFORMANT ADDRESS Wilma R. Farmer-dau-3800 Mt. Olney Lane, Olney, Md. (20832) | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Cardiac pulmonary arrest | | | | DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarct | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Coronary Arteriosclerosis | | | | DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Arteriosclerosis | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Recent myocardial infarct 4 weeks or | | | | 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | 22a. I certify that (I) (this hospital) attended the deceased from Oct 4, 1983 , to Dec 2, 1983 , that (I) (most) saw the deceased alive on Dec 2, 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death. | | | |
| 22b. SIGNATURE William Henry Killay M.D. | | | | 22c. DATE SIGNED Dec 5 83 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Henry Killay | | | |
| 22e. ADDRESS 8218 Union Ave Bethesda Md 20814 | | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 12-3-1983 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia | | | | 24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home | | | |
| 25a. DATE REC'D. BY REGISTRAR DEC 7 1983 | | | | 25b. REGISTRAR'S SIGNATURE John J. Canfield | | | | 25c. DATE REC'D. BY REGISTRAR DEC 7 1983 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

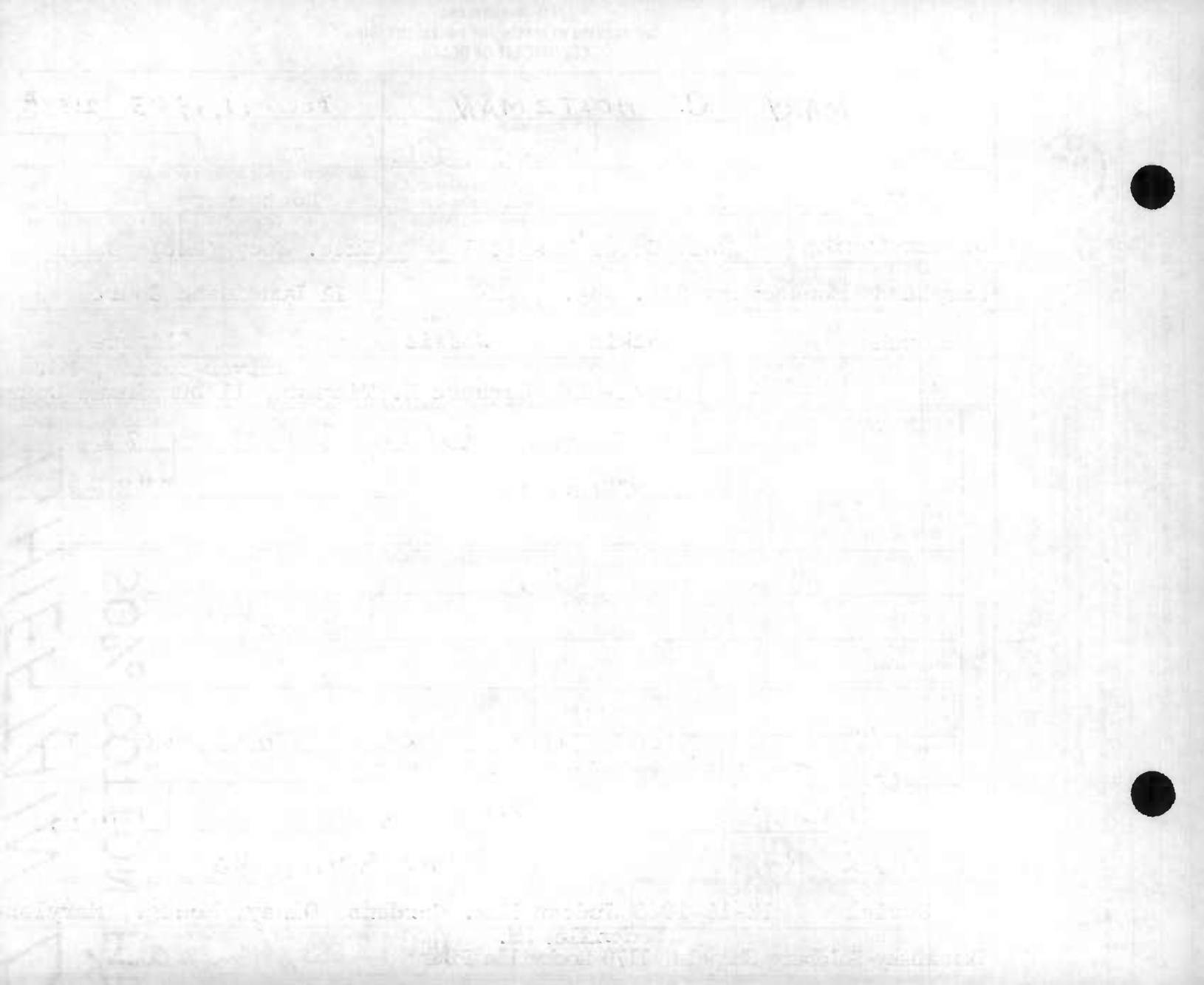
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARY C. HOLTZMAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 11, 1983 | | | 2b. HOUR
2:37 PM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 17, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Exec. Secy (Ret) Bank | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spg. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Morcha Platkin | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nessie Glinore | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
132-22-8138 | | 17. INFORMANT
Silver Spring, Md.
Herbert E. Tiemann; 11 Dunsinane Court | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute myocardial infarction
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 hours
20 years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
chronic renal failure | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/10 19 83 , to 12/10 19 83 , that (I) (we) lost saw the deceased alive on 12/10 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Mark Rosen | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/11/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mark Rosen | | | | 22e. ADDRESS
Silver Spring, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-13-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Judean Mem. Gardens | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Olney, Montg., Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | 25. DATE REC'D. BY REGISTRAR
DEC 12 1983 | | | | | |
| 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | | | | | | | |



20% COTTON

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHM-17
(VR A15 ME (1))
15M 2/80

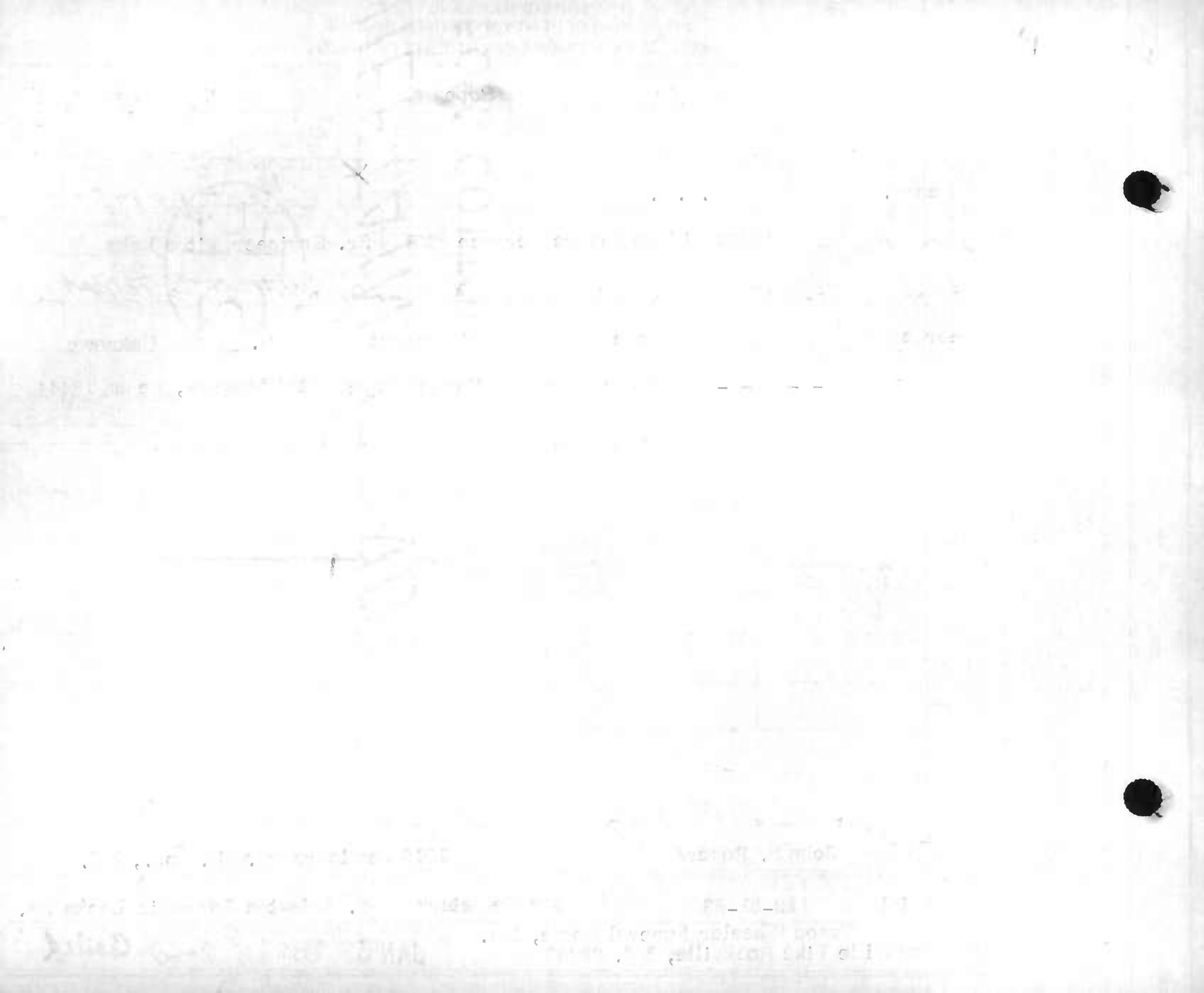
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33691

| | | | | | | | | |
|--|---------------------|--|---|---|---|---|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Margaret Elaine Hope</i> | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <i>12/18/83</i> | | | 2b. HOUR
<i>8 PM</i> | | |
| 3. SEX
<i>F</i> | 4. RACE
<i>W</i> | 5. DATE OF BIRTH
DAY MONTH YEAR
<i>Sept 25 1962</i> | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
<i>21 YRS.</i> | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD
<i>Dec. 27 1983</i> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Penna.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery MD.</i> | | |
| 10. CITY OR TOWN OF DEATH
<i>Rockville</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>12400 Village Square Terrace #201</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Sr. Engineer Vitro Labs</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
<i>MD</i> | | | 13b. COUNTY
<i>Mont.</i> | | 13c. CITY OR TOWN
<i>Rockville</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>George Hope</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Margaret H. Unknown</i> | | | 16. SOCIAL SECURITY NO.
<i>240 36 7999</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
<i>No</i> | | | 16b. SOCIAL SECURITY NO.
<i>240 36 7999</i> | | | 17. INFORMANT
ADDRESS
<i>Chyleen Carey Rt#4 Moscow, Penna 18444</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
<i>4291 Acute Myocardial Dis.</i>
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
<i>None</i> | | | | | | | | |
| 19a. DATE OF OPERATION
<i>None</i> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
<i>John S. Rogers</i> | | | TITLE (SPECIFY)
<i>Dep.</i> | | | MEDICAL EXAMINER
DATE SIGNED <i>Dec 27 1983</i> | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
<i>John S. Rogers</i> | | | ADDRESS
<i>1919 Seminary Rd. Sil. Spr., Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | | 23b. DATE
<i>12-31-83</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Shady Lane Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>S. Abington Township Lacka Pa.</i> | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Tyson Wheeler, Funeral Home, Inc.
1331 Rockville Pike Rockville, Md. 20852</i> | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 3 1984</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Gough</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
BEN HORNSTEIN | | | | | 2a. DATE OF DEATH
December 29, 1983 | | | 2b. HOUR
12:13 a.m. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
November 8, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Manager (Ret.) | | 12b. KIND OF BUSINESS OR INDUSTRY
Clothing Manuf. | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
George | | 15. MOTHER'S MAIDEN NAME
Anna | | 16. SOCIAL SECURITY NO.
061-05-9677 | | | | | |
| 17. INFORMANT
Adrienne Hornstein | | 18. ADDRESS
Silver Spring, Md. 20902 | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
061-05-9677 | | 17. INFORMANT
Adrienne Hornstein | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
4100
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/28/83 to 12/29/83, that (I) (we) last saw the deceased alive on 12/28/83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/29/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARK H. BIG, M.D. | | 22e. ADDRESS
9801 Georgia Ave., Silver Spring, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
1/3/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Lebanon Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Queens, New York | | | |
| 24. FUNERAL DIRECTOR
NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS
1170 Rockville Pike, Rockville, Md. 20852 | | 25a. DATE REC'D. BY REGISTRAR
JAN 03 1984 | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | | | |

25

LIBER

FRANK

10-11-1911

10-11-1911

10-11-1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/B1
(VRA 15, 4)



| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Peter Nicholas Horvath | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 25, 1983 | | | 2b. HOUR
3:00AM | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
August 14, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Hungary | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6606 Braeburn Parkway | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Dermatologist | | 12b. KIND OF BUSINESS OR INDUSTRY
Dermatology | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank S. Horvath | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Yolanda Wikkenhauser | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]
Yes WWII | | | | | 16b. SOCIAL SECURITY NO.
153-18-6196A | | 17. INFORMANT
Irene K. Horvath, Wife, Same as item #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma of Stomach</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last
1519 | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the undersigned) attended the deceased from <u>January</u> , 19 <u>83</u> , to <u>December 25</u> , 19 <u>83</u> , that (I) (we) saw the deceased alive on <u>December 21</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Paul V. Woolley MD</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
Dec. 26, 1983 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Paul V. Woolley, M.D. | | | | | 22e. ADDRESS
3800 Reservoir Road, N.W.
Washington, D.C. 20007 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
Dec. 27, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1983 | | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Connel</u> | | |

BP

Q1 V. Kelly and

COACH LIGHT

UNDO

WAVE

11

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|---|--|---|--------------------------------------|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Herbert Clay Hovermale | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-3-83 | | | 2b. HOUR
6:35 AM | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 28 60 | | 6. AGE (IN YEARS LAST BIRTHDAY)
22 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
AUTOMOTIVE MECH. | | 12b. KIND OF BUSINESS OR INDUSTRY
PUB. SCHOOLS | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
BETHESDA | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
10526 WESTLAKE DRIVE 20817 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HERBERT LEROY HOVERMALE | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
PEGGY JEAN BAMBERGER | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | |
| 16b. SOCIAL SECURITY NO.
212-84-9303 | | | 17. INFORMANT
SHERRI HOVERMALE, WIFE, BETHESDA, MD. | | | 18. ADDRESS
10526 WESTLAKE DR. 20817 | | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **cardiopulmonary arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost

(b) **acute leukemia**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 12/3/83 to 12/3/83 , that (1) (we) lost
saw the deceased alive on 12/3/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
D-T. HAIDAK | | | | DEGREE
MD | | 22c. DATE SIGNED
12/3/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
D-T. HAIDAK | | | | 22e. ADDRESS
6505 Belcrest Rd, Hyattsville, MD | | | |

| | | | | | | | |
|---|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
12/6/83 | | 23c. NAME OF CEMETERY OR CREMATORY
PARKLAWN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROCKVILLE MONT. MD. | |
| 24. FUNERAL DIRECTOR
NAME
RICHARD RAPP, INC., WASH. D.C. 20036 | | | | 25. DATE REC'D. BY REGISTRAR (b) REGISTRAR'S SIGNATURE
DEC 6 1983 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-2345.

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST PAUL MIDDLE ELDRIDGE LAST HOWELL
<i>Paul Eldridge Howell</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
12-26-83 | | | 2b. HOUR
4 AM | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
NOV. 22, 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Produce Merch. | | 12b. KIND OF BUSINESS OR INDUSTRY
Grocery | |
| 13a. STATE
Md. 20879 | | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Elijah - Howell | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Corā - Parish | | | 13e. STREET ADDRESS
9912 Forestview Place <i>20879</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT
ADDRESS
Marjorie B. Howell Same as # 13 | | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **left sided bacterial pneumonia**
1629
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) **metastatic lung cancer**
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to **December 26, 1983**, that (I) (we) last saw the deceased alive on **December 25, 1983**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|---|--|--|--|-------------------------------------|--|
| 22b. SIGNATURE
<i>Elliot P. Royston MD</i> | | DEGREE | | 22c. DATE SIGNED
12/26/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Elliot P. Royston | | 22e. ADDRESS
501 W. Frederick Ave. Gaithersburg, Md. 20879 | | | |

| | | | | | | | |
|---|--|-----------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Entombment | | 23b. DATE
Dec. 28, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Mont. Md. | |
| 24. FUNERAL DIRECTOR
Francis H. Barber Laytonville, Md. 20879 | | | | 25. DATE RECEIVED BY REGISTRAR
DEC 29 1983 | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



[Faint, mostly illegible text and markings across the page, possibly bleed-through from the reverse side. Includes various lines of text, some numbers, and a large, faint rectangular stamp in the center.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Elizabeth Yang | | LAST Hu | | 2a. DATE OF DEATH MONTH DAY YEAR
12 15 83 | | 2b. HOUR
2216
M | |
| 3. SEX
Female | | 4. RACE
Oriental | | 5. DATE OF BIRTH MONTH DAY YEAR
Sept. 9 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
China | | 7b. CITIZEN OF WHAT COUNTRY?
China | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery
MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. 20854 | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Potomac | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Kuan-Chang Yang | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ling-Jung Kao | | 16. STREET ADDRESS / ZIP CODE
11937 Goya Drive 20854 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
220-56-4647 | | 17. INFORMANT
Marybelle Reeves 11902 Remwood Lane. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
4149
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Atherosclerosis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2a mid
5 yrs. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
Severe cerebrovascular disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-19 , 19 80 , to 12-15 , 19 83 , that (I) (we) last saw the deceased alive on 12-6-83 , 19 83 , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the body after death. | | | | | | | |
| 22b. SIGNATURE
Samuel D. Goldberg MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-16-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Samuel D. Goldberg MD | | 22e. ADDRESS
11125 Rockville Pike Rockville, Md 20852 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
12/23/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Maryland. | |
| 24. FUNERAL DIRECTOR
NAME
Joseph Gawler's Sons Inc.
5130 Wisconsin Ave., N.W. Washington, D.C. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 21 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. G... .. | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HELEN MILLER HUDSON | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 14, 1983 | | | 2b. HOUR
11:45P M | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
JUNE 25 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN
89 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MICHIGAN | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
SANDY SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRIENDS NURSING HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PIANO TEACHER | | 12b. KIND OF BUSINESS OR INDUSTRY
Teacher | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SANDY SPRING | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
CALEB STABLER MILLER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARY S WILSON | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
NO (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
577-24-4658 A | |
| 17. INFORMANT
MEDICAL RECORDS | | ADDRESS | | | | | |

| | | | | | |
|--|--|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary failure
4292
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic CV disease | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24h
1mo
years | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/13/83 to 12/14/83 , that (I) (we) last saw the deceased alive on 12/13/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | |
| 22b. SIGNATURE H. H. Light | | DEGREE | | 22c. DATE SIGNED 12/15/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. H. Light MD | | 22e. ADDRESS 18111 P+Philip Dr. Olney MD 20852 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE DEC. 15, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Lee Crematory | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
Washington, D. C. | | 24. FUNERAL DIRECTOR NAME ADDRESS
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879 | | | |
| 25a. DATE REC'D BY REGISTRAR DEC 20 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Carter, R | | | |

BP

111



united states of america
national bank of commerce
new york

to the order of

for deposit only
no cash value
if not cashed

DEC 20 1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) DOROTHY MAE HURLEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. - 23 - 83 | | 2b. HOUR
7:25 P. | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 18, 1901 | 6. AGE (IN YEARS LAST BIRTHDAY)
82 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
At Home | |
| 13a. STATE
D.C. 20008 | | 13b. CITY OR TOWN
Washington | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS
4740 Connecticut Avenue, N.W. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Knight | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertie Bohannon | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
220-32-6553 | | 17. INFORMANT
ADDRESS 5933 Searl Terrace
Herbert E. Hurley, Jr., Bethesda, Md. 20816 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
0389 IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Septic
DUE TO, OR AS A CONSEQUENCE OF
(c) Lung mass
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Lung mass | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
— | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 12/23 , 19 83 , to 12/23 , 19 83 , that (1) (we) last saw the deceased alive on 12/23 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Dr Paul Kretting | | DEGREE MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12/23/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr Paul Kretting | | 22e. ADDRESS
1109 Spring St Silver Spring, Md 20910 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/27/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Maryland |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.
NAME ADDRESS
5130 Wisconsin Ave., NW, Washington, D.C. 20016 | | | | 25. DATE REC'D. BY REGISTRAR DEC 30 1983
REGISTRAR'S SIGNATURE
John J. Connel | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR | | | |
| I. DECEASED NAME FIRST MIDDLE LAST
Dessie M. IREMAN | | | | 12/12/83 4:30 AM | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
7/5/1891 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Michigan | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY
G.S.A. | |
| 13a. STATE
Md. 20816 | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Joseph W. IREMAN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Florence B. (Unknown) | | 13e. STREET ADDRESS
4926 River Road 20816 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
579-0309627 | | 17. INFORMANT ADDRESS
Gloria Rigglesman, P.O. Box 311, Montchanin Del. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4140 IMMEDIATE CAUSE (a) Congestive Heart Failure & Renal Failure 2 weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Disease 10 years
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/11/83 to 12/12/83, that (I) (we) last saw the deceased alive on 12/11/83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (they) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Michel M Healy MD | | | | 22c. DATE SIGNED
12/12/83 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michel M HEALY MD | |
| 22e. ADDRESS
5652 Shields Dr. Bethesda MD | | | | 22f. DATE REC'D BY REGISTRAR 12/19/83 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/14/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Suitland Maryland. | |
| 24. FUNERAL DIRECTOR NAME
Joseph Gawler's Sons Inc. C. | | | | 25. DATE REC'D BY REGISTRAR 12/19/83 | | | |
| 25a. ADDRESS
2150 Wisc. Ave., N.W. Wash., D.C. | | | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | | | |

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Printed

15/04/83 Carter Hill Community

600-7111

• Prüfung

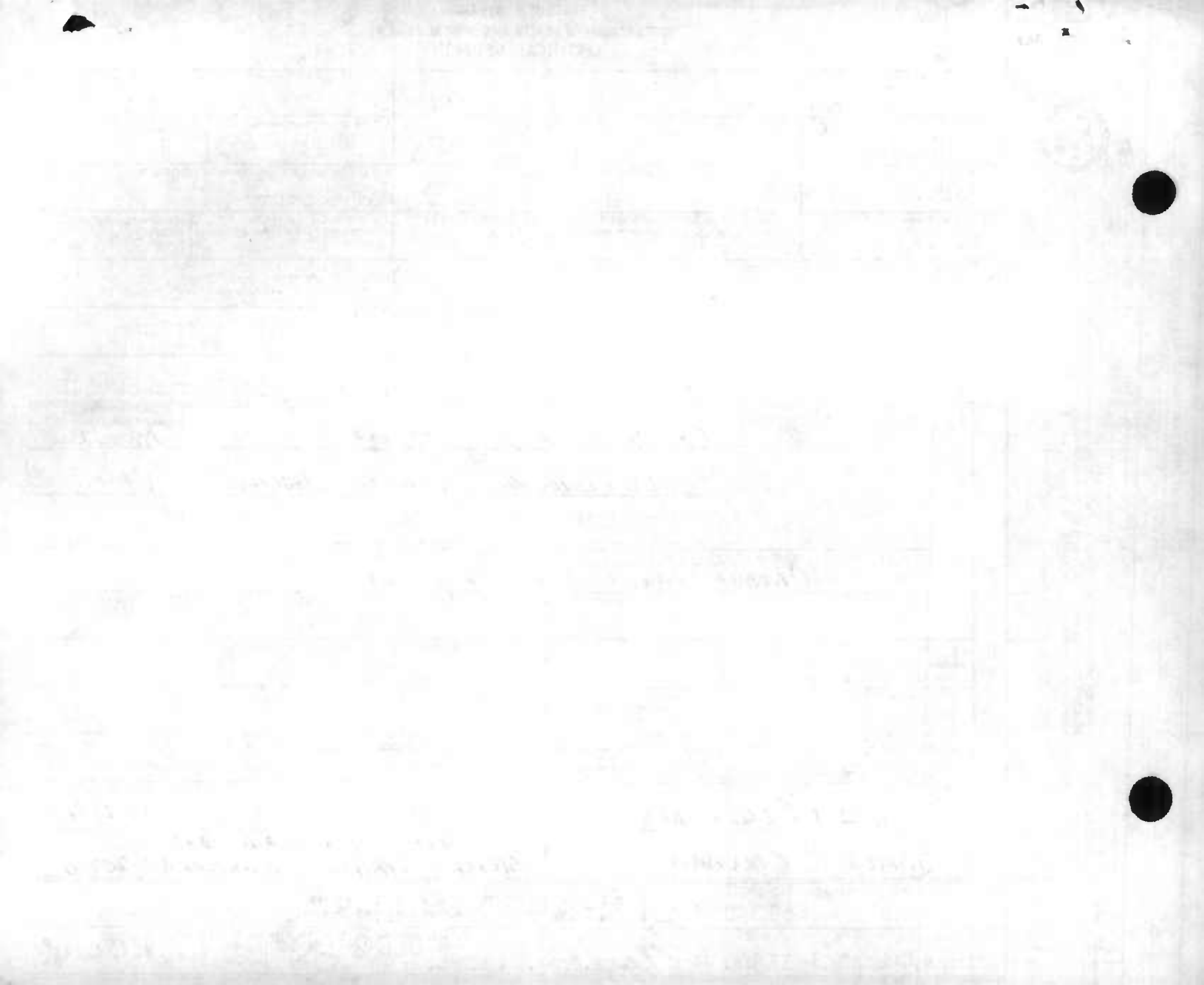
THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5890.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) George E. Jacobson | | | | 2a. DATE OF DEATH
MONTH 12 DAY 27 YEAR 83 | | | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH 10 DAY 22 YEAR 93 | | 6 AGE (IN YEARS LAST BIRTHDAY)
90 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mass. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10 CITY OR TOWN OF DEATH
S.S. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Carriage Hill Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
US Gov't. | | 12b. KIND OF BUSINESS OR INDUSTRY
Naval Res. Lab. | |
| 13a. STATE
Md. | | | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
S.S. | |
| 14 FATHER'S NAME
FIRST Charles MIDDLE Jacobson | | | | 15. MOTHER'S MAIDEN NAME
FIRST Augusta MIDDLE Olson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
579 26 6964 | | 17 INFORMANT
ADDRESS
Alice I. Jacobson (Wife) Same as 13E | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
4409
DUE TO, OR AS A CONSEQUENCE OF
(b) arteriosclerotic vascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic organic brain syndrome. | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Immed
year |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
Chronic organic brain syndrome. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from 11/12 , 19 82 , to 12/27 , 19 83 , that (I) (we) last saw the deceased alive on 12/16 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
James R. Coleman MD. | | | | DEGREE
MD. | | 22c. DATE SIGNED
12/27/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES R. COLEMAN | | | | 22e. ADDRESS
9241 COLUMBIA BLVD
SILVER SPRING MARYLAND 20910 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/30/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery Brentwood PG Maryland | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24 FUNERAL DIRECTOR
NAME
Hines/Rinaldi | | | | ADDRESS
11800 New Hamp. Ave. S.S. Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Dennis C Jenkins | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-17-83 | | 2b. HOUR
1:00 A.M. |
| 3. SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
10-16-10 | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MILKMAN ROUTE SALESMAN | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
WHEATON | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
11402 MONTERREY DRIVE 20902 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John William Jenkins | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
578-05-1308 | | 17. INFORMANT
NAME ADDRESS
Julia Jenkins Wife Same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio - Respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Decompensated liver disease + malabsorption syn.
DUE TO, OR AS A CONSEQUENCE OF (c) Severe diffuse Pulmonary Interstitial disease | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/27/83 , to 12/17/83 , that (I) (we) last
saw the deceased alive on 12/16/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Tony P. KANNARKAT | | DEGREE
MD | | 22c. DATE SIGNED
12/17/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
TONY P. KANNARKAT, MD | | 22e. ADDRESS
8201 16th St S.S. MD 20910 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 20, 1983 | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery Silver Spring Mont. Md. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins | | ADDRESS
500 University Blvd. W. Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 23 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. Gair | |

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND 8 3
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| FOR
1 - STATE
REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | REG. NO. | | | | | |
|--|--|---|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
<small>(TYPE OR PRINT)</small>
<div style="display: flex; justify-content: space-between;"> FIRST
<i>MILAN</i> MIDDLE
<i>W.</i> LAST
<i>JERABEK</i> </div> | | | | | | | | 2a. DATE OF DEATH
<small>MONTH DAY YEAR</small>
<div style="display: flex; justify-content: space-between;"> <i>12-15-83</i> HOUR
<i>5²⁵ PM</i> </div> | | | | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH
<small>MONTH DAY YEAR</small>
<i>March 24 1916</i> | | 6. AGE <small>(IN YEARS LAST BIRTHDAY)</small>
<i>67</i> YRS.
<small>IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.</small> | | | | | | | |
| 7a. BIRTHPLACE
<small>(STATE OR FOREIGN COUNTRY)</small>
<i>MARYLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA.</i> | | 8.
MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery MD.</i> | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
<small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small>
<i>Suburban Hospital Dept of State</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>U.S. Govt.</i> | | | | | | | |
| USUAL RESIDENCE <small>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)</small>
13a. STATE <i>MD.</i> 13b. COUNTY <i>Mont.</i> 13c. CITY OR TOWN <i>Kensington</i> | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 14. FATHER'S NAME
<small>FIRST MIDDLE LAST</small>
<i>Emil (N/A) Jerabek</i> | | | | 15. MOTHER'S MAIDEN NAME
<small>FIRST MIDDLE LAST</small>
<i>Christine (N/A) Totushek</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
<small>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)</small>
<i>yes WWII</i> | | 16b. SOCIAL SECURITY NO.
<i>470-146489</i> | | 17. INFORMANT
<i>Janette Jerabek (same as #13)</i> | | | | | | | | | |
| 18. CAUSE OF DEATH <small>Enter only one cause per line for (a), (b), and (c).</small>
PART I. DEATH WAS CAUSED BY:
<div style="display: flex; align-items: flex-start;"> <div style="flex: 1;"> <p>IMMEDIATE CAUSE (a) <i>Acute massive myocardial infarction</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(b) <i>atherosclerotic heart disease</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) _____</p> </div> <div style="flex: 1; padding-left: 10px;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
 <i>80 hours</i>
 <i>years</i></p> </div> </div> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
<small>(IF EITHER NOTIFY MEDICAL EXAMINER)</small> | | | | 21b. TIME OF INJURY
<small>HOUR A.M. MONTH DAY YEAR</small>
<div style="display: flex; justify-content: space-between;"> P.M. <i>19</i> </div> | | | | 21c. HOW INJURY OCCURRED <small>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)</small> | | | | | |
| 21d. INJURY OCCURRED
<small>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></small> | | | | 21e. PLACE OF INJURY
<small>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)</small> | | | | 21f. LOCATION
<small>STREET CITY OR TOWN COUNTY STATE</small> | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>12-13-1983</i> , to <i>12-15-1983</i> , that (I) (we) lost saw the deceased alive on <i>12-15-1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Joseph A. Romeo MD</i> | | | | | | | | DEGREE
<i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12/16/83</i> | |
| 22d. PHYSICIAN'S NAME <small>(TYPE OR PRINT)</small>
<i>Joseph A. Romeo MD</i> | | | | | | | | 22e. ADDRESS
<i>10401 Old Georgetown Rd., Bethesda, Md. 20814</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
<small>(SPECIFY)</small>
<i>Cremation</i> | | | | 23b. DATE
<i>20 Dec 83</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Lee Funeral Home</i> | | | | 23d. LOCATION
<small>CITY OR TOWN COUNTY STATE</small>
<i>WASH DC D.C.</i> | | | |
| 24. FUNERAL DIRECTOR
<small>NAME ADDRESS</small>
<i>Hal Lenson FH, 9013 Nanpotis Rd MD</i> | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 30 1983</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

Handwritten notes at the top of the page, including "1964" and "1965".

Handwritten notes in the upper middle section, including "1964" and "1965".

Handwritten notes in the middle section, including "1964" and "1965".

Handwritten notes in the lower middle section, including "1964" and "1965".

Handwritten notes in the lower section, including "1964" and "1965".

Handwritten notes in the lower section, including "1964" and "1965".

Handwritten notes at the bottom of the page, including "1964" and "1965".

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 17 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

33703
REG. NO.

| | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|---|--|
| FOR
1- STATE
REGISTRAR | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | MONTH DAY YEAR
12 28 83
19 | | 2b. HOUR
9:54
PM | |
| 1. DECEASED NAME
(TYPE OR PRINT)
John nmn Jewell | | 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 28 11 | | 6. AGE (IN YEARS
LAST BIRTHDAY)
72 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 7c. DATE
PRONOUNCED
DEAD
12 28 83
19 | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
Georgia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County | | 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
Janitor | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Takoma Park | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7603 Eastern Ave #201 | | 12b. KIND OF BUSINESS
Hospital | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Jewell | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Almetta Bell | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Lillie Jewell (Wife) | | ADDRESS
7603 Eastern Ave, NW. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
4291 IMMEDIATE CAUSE (a) <u>Acute Myocardial Dia</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE
<i>John R. Rogers</i> | | TITLE (SPECIFY)
M.D. Dep. | | | | | | | | MEDICAL EXAMINER | | DATE
SIGNED
Dec 29 1983
MD | |
| EXAMINER'S NAME
(TYPE OR PRINT)
John R. Rogers | | MD | | ADDRESS
1919 Symnary Rd, Silver Springs | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/3/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Lincoln Cemetery | | | | 23d. LOCATION
(CITY OR TOWN) COUNTY STATE
Suitland, PGC, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Modern Funeral Home | | 3821-14th St, N.W. Wash, D.C. | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Connel</i> | | | | | | | |



18-211
11-11

Montgomery County

18-211

18-211

18-211

18-211

18-211

18-211

18-211

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

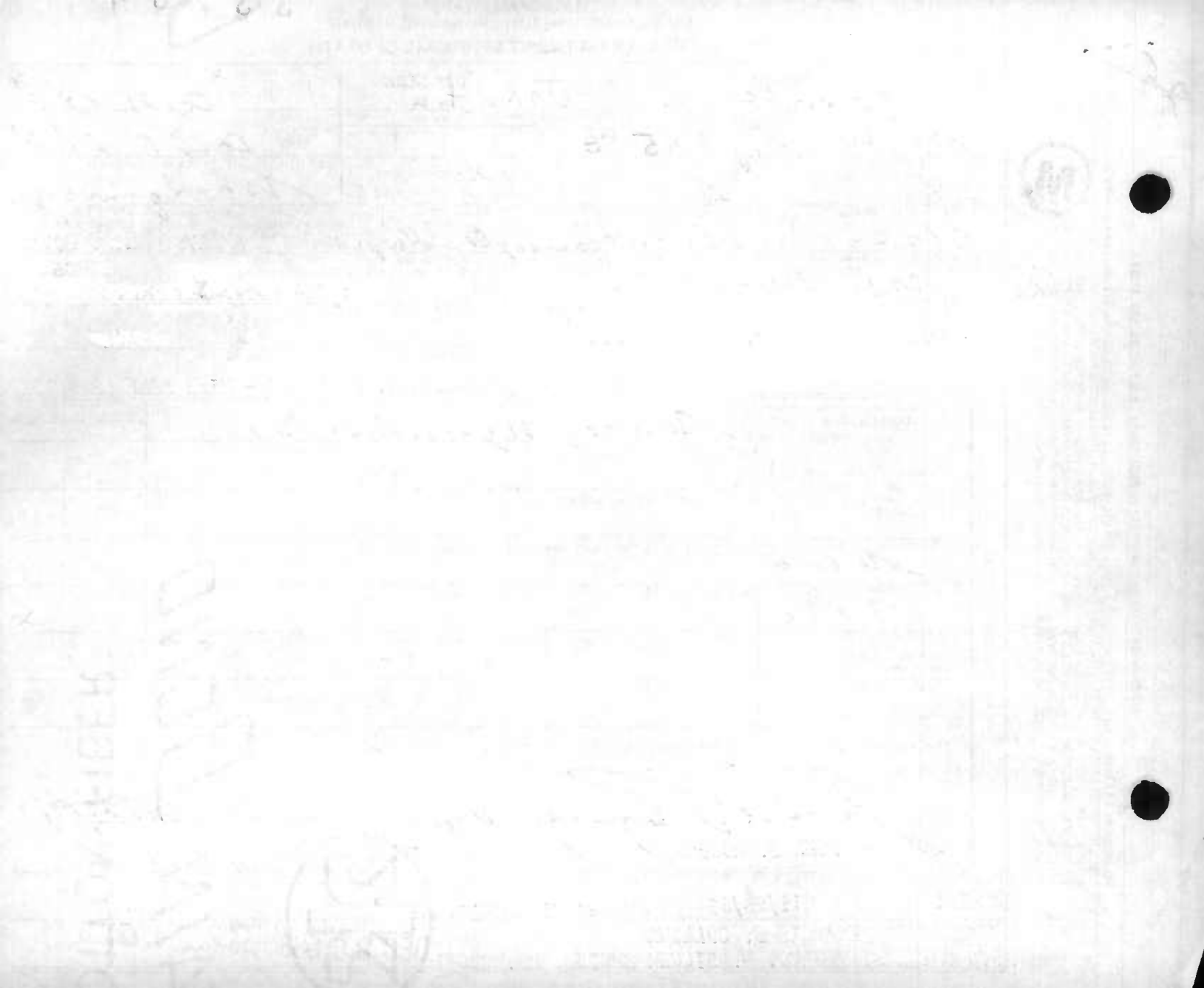
BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|---------------------|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | | | | | | | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Vance | | M. | | Johnston | | | | Dec 21 | | 19 | | 83 | | P | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YR. | | 8. IF UNDER 24 HRS. | | 9. DATE PRONOUNCED DEAD | | 10. HOUR | |
| M | | W | | Aug 9 05 | | 78 YRS. | | | | | | Dec 21 1983 | | P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| NEW YORK | | USA | | | | Montgomery | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Biney | | Montgomery Care Hosp | | | | | | | | | | FINANCIAL ANALYST | | U.S. GOV't | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | |
| MD | | Montgomery | | B. J. J. | | | | 40522 Haselmeire Court 20906- | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16. SOCIAL SECURITY NO. | | | | | | | |
| VANCE M. JOHNSTON | | | | ELLEN GAGE | | | | 080-01-2979 | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | |
| NO | | | | 080-01-2979 | | | | REBECCA N. JOHNSTON - WIFE SAME AS # 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute Myocardial Dist</u> | | | | | | | | | | | | | | | |
| 4291 | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | |
| None | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | |
| None | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | |
| | | | | | | | | CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| TITLE (SPECIFY) | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | M.D. Rogers | | | | MEDICAL EXAMINER | | | | DATE | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | DEC 23 1983 | | | |
| JOHN S. ROGERS, MD | | | | SILVER SPRING, MARYLAND | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | |
| BURIAL | | | | 12/26/83 | | | | SPRING HILL CEMETERY | | | | EASTON MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| FRANCIS J. COLLINS | | | | DEC 28 1983 | | | | John J. Calver | | | | | | | |
| 500 UNIVERSITY BLVD. W. SILVER SPRING, MD. 20901 | | | | | | | | | | | | | | | |



Cleared by Med. Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|--|--|---|---|--|---|---|
| 1. FOR STATE REGISTRAR | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) GYNETH M. JONES | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 6 83 | | 2b. HOUR 6:35 P.M. | |
| 3. SEX FEMALE | | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 2/10/22 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIANA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RESEARCH ANALYST | | 12b. KIND OF BUSINESS OR INDUSTRY SMALL BUSINESS ADM. |
| 13a. STATE MARYLAND | | | 13b. COUNTY MONTGOMERY | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS 1012 LOXFORD TERRACE 20901 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM H. ARTHUR | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GLENDORA LAMBERT | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 314-16-9478 | | 17. INFORMANT ADDRESS PAUL O. JONES SAME AS 13 HUSBAND | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
4/00
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hour
2 hours
years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/15 , 19 83 , to 12/16 , 19 83 , that (I) (we) lost saw the deceased alive on 12/16 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) did not view the body after death. | | | | | | |
| 22b. SIGNATURE Alan W. Eustace | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/16/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan W. Eustace | | 22e. ADDRESS 1299 Lambert Ave Silver Spring MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12/9/83 | 23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT MD. | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS | | | | 25a. DATE REC'D. BY REGISTRAR DEC 13 1983 | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | REGISTRAR'S SIGNATURE John J. Smith | | |



121-4444

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, burial shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 706 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
<u>Frances Donohoe Jordan</u> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>12 27 83</u> | | | 2b. HOUR
<u>9A</u> M | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>Caucasian</u> | | 5. DATE OF BIRTH MONTH DAY YEAR
<u>January 22 1915</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>68</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Washington, D.C.</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery</u> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<u>Chevy Chase</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>8101 Connecticut Avenue # 608</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Homemaker</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <u>Maryland</u> 13b. COUNTY <u>Montgomery</u> 13c. CITY OR TOWN <u>Chevy Chase</u> | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<u>8101 Connecticut Avenue #608 20015</u> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<u>Milburn J. Donohoe</u> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<u>Katherine Markey</u> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<u>No</u> | | 16b. SOCIAL SECURITY NO.
<u>215-26-3193</u> | | 17. INFORMANT ADDRESS
<u>Joseph P. Jordan Husband Same as 13</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Arteriosclerotic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Essential Hypertension</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 hour</u>
<u>10 yrs</u>
<u>10 yrs</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Aug. 8, 1972</u> to <u>Dec. 27, 1983</u> , that (1) (we) lost saw the deceased alive on <u>Dec. 13, 1983</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Joseph J. Wallace, M.D.</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/27/83</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Joseph J. Wallace, M.D.</u> | | | | 22e. ADDRESS
<u>5272 River Road Bethesda, Maryland</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>Dec. 30, 1983</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Olivet Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<u>Washington, D. C.</u> | | | |
| 24. FUNERAL DIRECTOR NAME
<u>Francis J. Collins</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>JAN 6 1984</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Jan J. Collins</u> | | | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | | | | | |

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mabel Fox Kauffman | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 22, 1983 | | | 2b. HOUR
8 ¹⁵ M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 9, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS | | 7. UNDER 1 YEAR
MONTHS DAYS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
11820 Gordon Road, 20904 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harry Clifford Fox | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Euphemia Ellen Utterbaugh | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
ADDRESS
Clifford J. Kauffman-son- (same as 13e) | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

2080

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) Acute leukemia

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

24 hours

1 month

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

Renal cell Carcinoma - 1 1/2 yr

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from 8-9 1982 to 12-22 1983, that (1) (we) last saw the deceased alive on 12-22 1983, and that in my (our) opinion death occurred on the date and hour and from the cause(s) stated above; (2) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Morton Shapiro, MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-23-83 | |
| 22d. PHYSICIAN'S NAME (PRINT OR PRINT) | | | | 22e. ADDRESS
5225 Pooks Hill Road, Bethesda, Md. 20814 | | | |

| | | | | | | | |
|--|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 27, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
11800 N.H. Ave.,
Silver Spring, Md. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 27 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Lola Y Kelley | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-20-83 | | | 2b. HOUR
4:20 A.M. | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
10-15-97 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD. | | 13b. COUNTY
MONT. | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1300 MIMOSA LANE | |
| 14. FATHER'S NAME
Lloyd MIDDLE | | | | 15. MOTHER'S MAIDEN NAME
Minnie MIDDLE | | 16. Gough | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
578 32 6750 | | 17. INFORMANT 3205 Regina Dr. S.S. Md.
Marcella Bowman (Daughter) | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CEREBRAL INFARCTIONAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**3 WEEKS**

4340
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **CEREBRAL ARTERY THROMBOSIS****3rd WEEKS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

CONGESTIVE HEART FAILURE, CHRONIC. SYSTOLIC HYPERTENSION

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE , 19 58 , to DEC. 20 , 19 83 , that (I) (we) last
saw the deceased alive on 12/20 , 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
James A. Roberts | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF
DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/20/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES A. ROBERTS | | 22e. ADDRESS
8907 GEORGIA AVE. SILVER SPRING, MD. | | | | | |

| | | | | | | | |
|---|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/22/83 | | 23c. NAME OF CEMETERY OR CREMATORY
St. John's Cemetery | | 23d. LOCATION
Forest Glen Mont. Md. | |
|---|--|------------------------------|--|--|--|---|--|

| | | | | | |
|--|--|---|--|---|--|
| 24. FUNERAL DIRECTOR
Hirres/Rinaldi 11800 New Hampshire S.S. Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 20 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | |
|--|--|---|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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10-12-12



10-12-12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) JOHN JOSEPH KELLY | | | 2a. DATE OF DEATH
MONTH DAY YEAR 12.17.83 | | 2b. HOUR
1040 M |
| 3. SEX
Male | 4. RACE
COLO | 5. DATE OF BIRTH
MONTH DAY YEAR 03 07 26 | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
NEW YORK | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
COLLINGWOOD NURSING HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TARIFF EX. | 12b. KIND OF BUSINESS OR INDUSTRY
I.C.C. | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
ROCKVILLE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN KELLY | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNE MCCARTNEY | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO.
103-18-4678 | 17. INFORMANT
ADDRESS
ANNE V. KELLY WIFE SAME AS 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory arrest,
1550
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic liver disease - Hepato Carcinoma.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/1983 , 19____, to 12/17 , 19 83 , that (I) (we) lost
saw the deceased alive on 12/14/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Hamid Montakhab MD | | DEGREE
MD | | 22c. DATE SIGNED
12/18/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HAMID MONTAKHAB MD | | 22e. ADDRESS
6111 Executive Blvd Rockville MD 20852 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
DEC. 21, 1983 | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ARLINGTON VA. |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | 25a. DATE REC'D. BY REGISTRAR
DEC 23 1983 | | |
| 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. | | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 1 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|---------------|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Robert | | MIDDLE
G. | LAST
Kelly | 2a. DATE OF DEATH MONTH DAY YEAR
12-26-83 | | | | 2b. HOUR ²⁰
1:20 A.M. | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 18 14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 yrs YRS. | | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. - Navy | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY
Maryland Montgomery | | | | | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
412 Hillmoor Drive 20901 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Kelly | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillian Barclay | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
199-07-0509 | | 17. INFORMANT ADDRESS
Mildred B. Kelly Wife Same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1539 Metastatic carcinoma of colon
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma of colon
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 months
2 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1982 to Dec 26 1983, that (he) (was) lost saw the deceased alive on Dec 25 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Raymond Bradshaw, MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Dec 26, 1983 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Raymond Bradshaw, Jr., MD | | | | | | 22e. ADDRESS
345 University Blvd, W Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Dec. 28, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
West Laurel Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Philadelphia Pa | | | |
| 24. FUNERAL DIRECTOR
NAME Francis J. Collins
ADDRESS 500 University Blvd., W. Silver Spring, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 28 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | | | |

BP _____

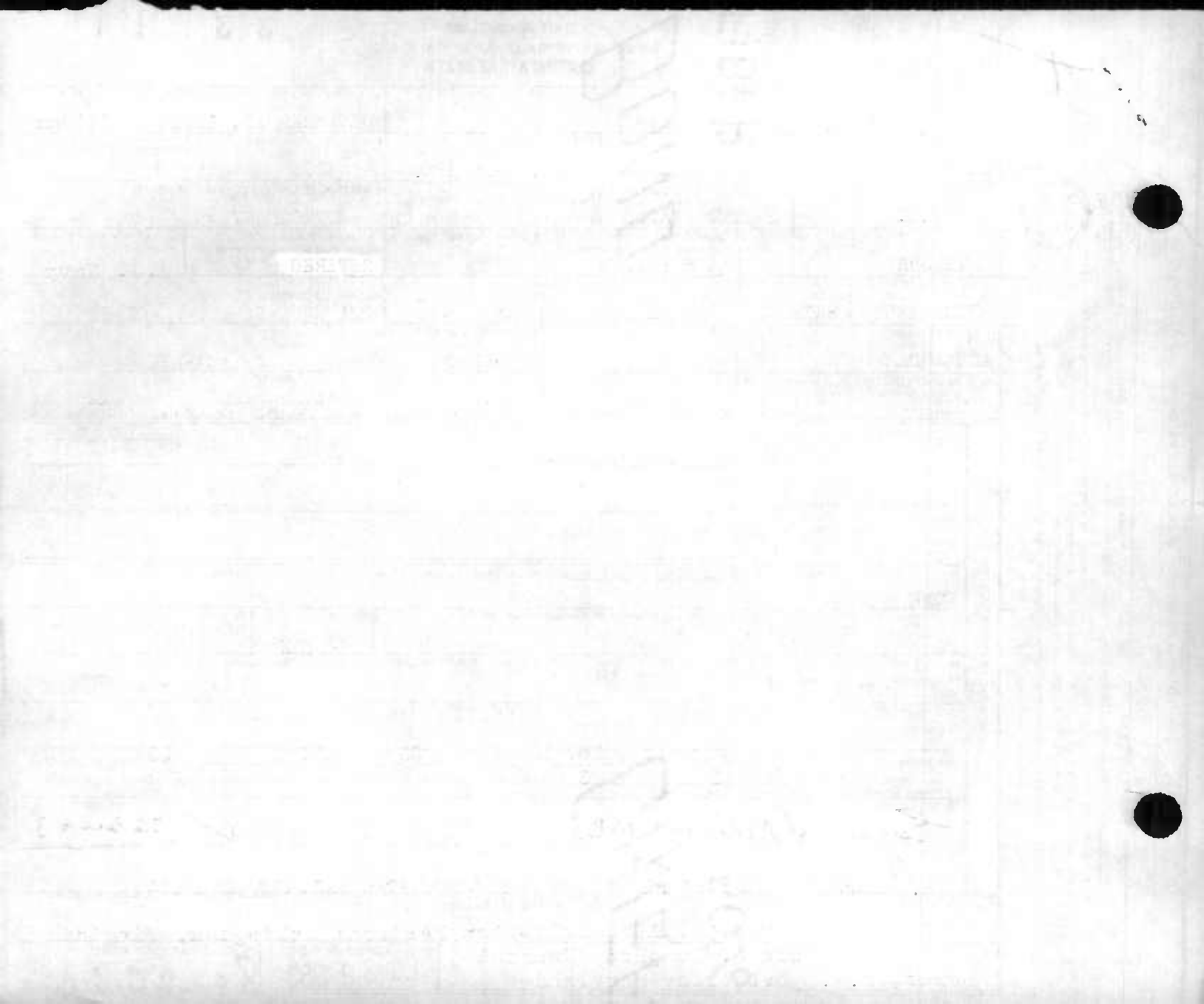
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

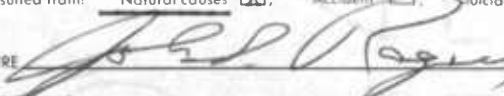
| | | | | | | | |
|--|--|--|--|---|---------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WALTER ALEXANDER KELSO | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 25, 1983 | | 2b. HOUR
1:10am | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
DEC 18 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY County MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Chief Petty Officer U.S. Navy | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
RHODE ISLAND | | 13b. CITY OR TOWN
BRISTOL | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
221 HOPE STREET 02809 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ALEXANDER KELSO | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
AGNES CARLIN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
1943-1966 110-12-3889 | | 17. INFORMANT ADDRESS
JOAN HUTZLER 34 OAK KNOLL DR., BERWYN, PA | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
1629 IMMEDIATE CAUSE (a) LUNG CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
NONE | | | | | | | |
| 19a. DATE OF OPERATION
NA | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOV 18 , 19 83 , to DEC 25 , 19 83 , that (I) (we) last saw the deceased alive on DEC 25 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Eugene S. Killeavy MD</i> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
26 Dec 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
E. KILLEAVY, LT, MC, USNR | | | | 22e. ADDRESS
NAVAL HOSPITAL BETHESDA MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 27, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Virginia | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | | | 25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE
DEC 29 1983 <i>John J. Carver</i> | | | |

MEDICAL CERTIFICATION



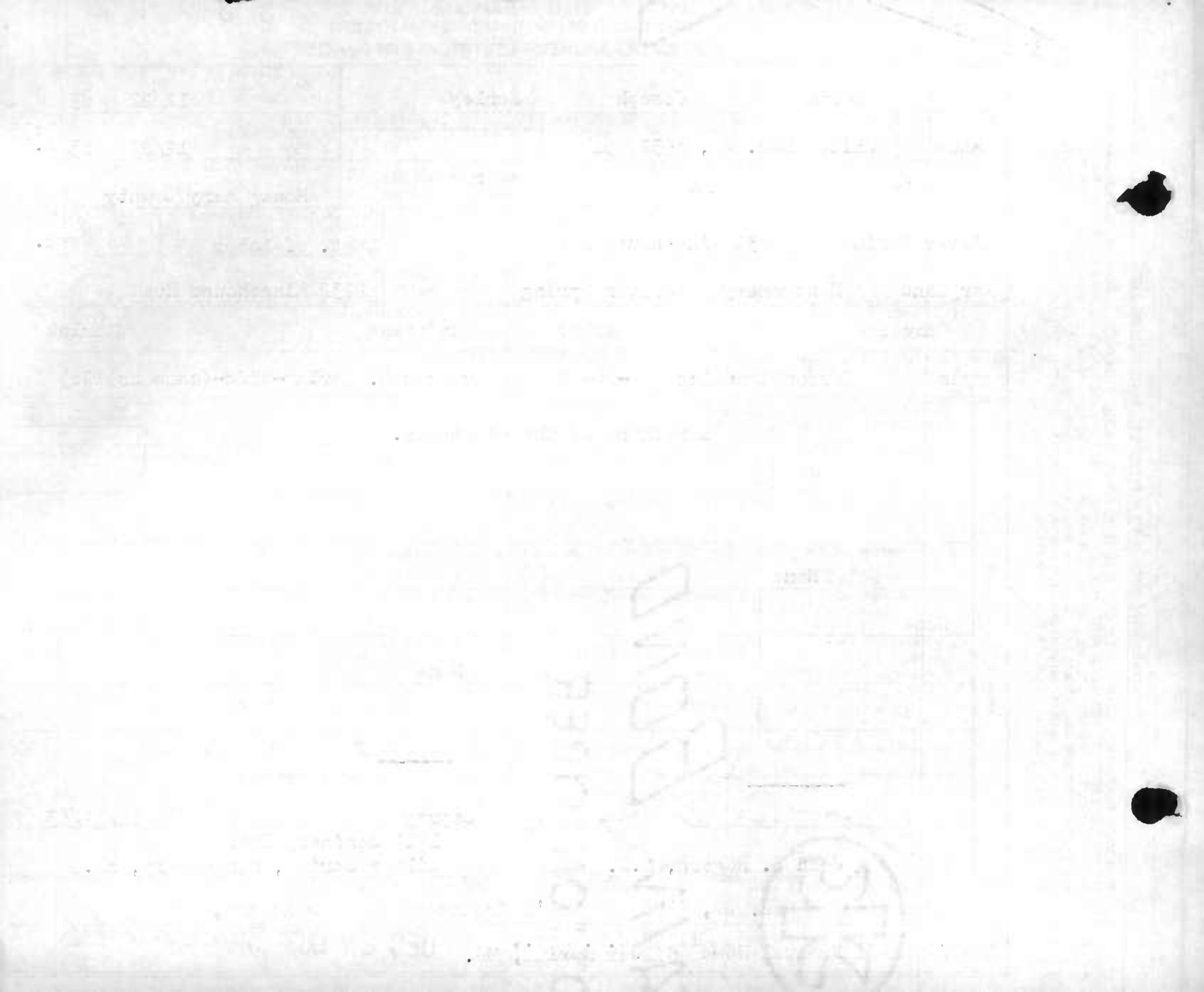
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST
Edwin Joseph Kerley | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
12/22 19 83 | | 2b. HOUR
A. 5:55 M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 20, 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY)
51 YRS. | | 7. IF UNDER 1 YR. IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Arizona | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2232 Kingshouse Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Dept. of Labor | | 12b. KIND OF BUSINESS OR INDUSTRY
US Govt. | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2232 Kingshouse Road | |
| 14. FATHER'S NAME
George MIDDLE | | | | 15. MOTHER'S MAIDEN NAME
Madalene MIDDLE | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) yes Korean Conflict | | | |
| 16a. SOCIAL SECURITY NO.
526-34-8898 | | | | 17. INFORMANT ADDRESS
Margaret M. Kerley-wife-(same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
1509
IMMEDIATE CAUSE (a) Carcinoma of the esophagus.
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
None | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
None | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | TITLE (SPECIFY)
Deputy M.D. | | | MEDICAL EXAMINER
1919 Seminary Road | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
John S. Rogers, M.D. | | | ADDRESS
Silver Spring, Montgomery, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
Dec. 27, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, DC | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi Funeral Home ADDRESS
11800 N.H. Ave., Silver Spring, Md. | | | | | 25. DATE REC'D. BY REGISTRAR
DEC 27 1983 | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARY Elizabeth Kinzie | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 27 83 | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 29 1937 | | 6. AGE (IN YEARS LAST BIRTHDAY)
46 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Artist | | 12b. KIND OF BUSINESS OR INDUSTRY
Self-Employed | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Md. STATE
Md. 20816 | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
M. J. Ellis | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary E. Spillman | | 13e. STREET ADDRESS
6300 Avalon Drive 20816 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-34-8889 | | 17. INFORMANT
ADDRESS
Robert W Kinzie. Same as item 13. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brain Stem Compression
4329
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intracranial Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
11 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
14 Intension. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Dec 16, 1983 , to Dec 27, 1983 , that (I) (we) lost saw the deceased alive on Dec 26, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Dr. Fleet Luckett MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-27-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Wm Fleet Luckett | | | | 22e. ADDRESS
5200 Reno Rd NW Wash DC. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/28/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Wicomio Memo. Park Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Salisbury Maryland. | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons Inc.
5130 Wisc. Ave., N.W. Wash., D.C. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1983 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed without delay after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Agnes L. LUCILLE Kirk | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/12/83 | | 2b. HOUR
0020 M | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
01 16 19 | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ALABAMA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Hospital Center Inc | | 12a. USUAL OCCUPATION
(GIVE WORK FOR MOST OF WORKING LIFE)
Assembly | | 12b. KIND OF BUSINESS OR INDUSTRY
Elect. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Md | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Gaithersburg | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
519 S. Frederick Ave #106 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Leon Thomas Waits | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Onnie Hart | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
417-30-4092 | | 17. INFORMANT ADDRESS
W.G. Kirk Same as # 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Oat Cell Lung Cancer
1629
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/12 , 19 83 , to 12/12 , 19 83 , that (I) (we) lost saw the deceased alive on 12/11 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Susan Plentlow UP | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/12/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SUSAN J. WITHROW | | | | 22e. ADDRESS
15E Deer Park, Gaithersburg Md | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 14, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Laytonsville | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Laytonsville Mont. Md. |
| 24. FUNERAL DIRECTOR
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879 | | | | 25. DATE RECEIVED BY REGISTRAR
DEC 16 1983 | | |

BP _____

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Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The" and "and" are visible.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Delma Mae Knight | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 10, 1983 | | 2b. HOUR
10:47P M | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 2, 1918 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
65 | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
United States | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 13a. STREET ADDRESS
700 Ritchie Avenue 20910 | | | |
| 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William H. Roberts | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah E. Robertson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215-34-2988 | | 17. INFORMANT ADDRESS
Robert L. Knight, same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
4415
DUE TO, OR AS A CONSEQUENCE OF
(b) probable aortic rupture
DUE TO, OR AS A CONSEQUENCE OF
(c) arteriosclerosis | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 hr
1 hr
2 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 55 , to 12/10 , 19 83 , that (I) (we) lost
saw the deceased alive on 9/9 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
William D. Aud | | DEGREE
MD | | 22c. DATE SIGNED
12/11/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William D. Aud, M.D. | | 22e. ADDRESS
9006 Colesville Road
Silver Spring, MD 20910 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 14, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
George Washington Cem. Adelphi, Maryland | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Maryland 20850 | | 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1983 | |
| 25b. REGISTRAR'S SIGNATURE
John J. Gairish | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Grace M. Knight | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 8, 1983 | | | 2b. HOUR
4:10 P.M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 10 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Ashton | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Christopher Kisner | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice Gittings | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
N/A N/A | | | |
| 16b. SOCIAL SECURITY NO.
213-74-4445 | | | 17. INFORMANT
ADDRESS
Mildred M. Knight-daughter-(same as 13e) | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary edema, acute</u>
4292
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Congestive heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Left ventricular hypertrophy, chronic</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr
2 wks
3 mos | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>55</u> , to <u>Dec</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/8</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>A. D. Bonifant</u> | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/8/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dement Bonifant, M.D. | | | 22e. ADDRESS
18111 Prince Philip Dr. Olney, MD. 20832 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Dec. 12, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Montgomery Md. | | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home | | | 11800 N.H. Ave.,
Silver Spring, Md. | | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1983 | | 25b. REGISTRAR'S SIGNATURE
<u>John J. L...</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 must be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

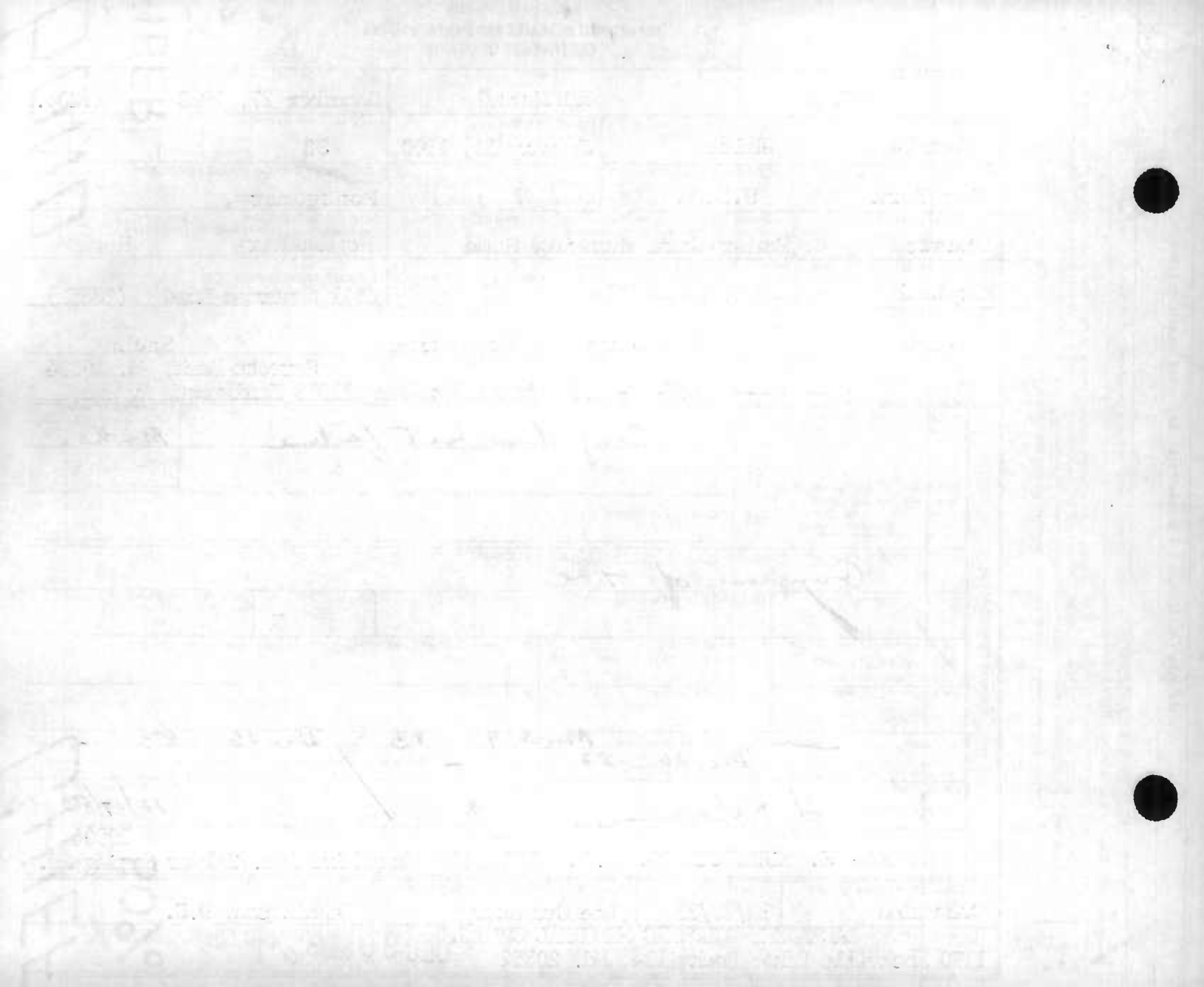
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|---|--|---|--|---|-----------------------------|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
HELEN KORNBERG | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 27, 1983 | | | | 2b. HOUR
1:20p.m. | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
January 31, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Manor Care Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6111 Montrose Road (20852) | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Jacob Blumberg | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Ernestine Sachs | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
058-22-8035 | | 17. INFORMANT ADDRESS
Garrett Park, Md. 20896
Warren Kornberg; 11019 Kenilworth Avenue; | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4280 Congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
Gangrene of toe | | | | | | | | | | | |
| 9a. DATE OF OPERATION | | | | 9b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHEN <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 9, 1983 , to Dec 26, 1983 , that (we) last saw the deceased alive on Dec 26, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Norman H. Rubenstein | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/29/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
NORMAN H. RUBENSTEIN, M.D. | | | | | | 22e. ADDRESS
11161 New Hampshire Ave.; Silver Spring, Md. 20904 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | | 23b. DATE
12/28/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR
DANZANSKY-GOLDBERG MEMORIAL CHAPELS | | | | | | 25. DATE RECD. BY REGISTRAR REGISTRAR'S SIGNATURE
DEC 30 1983 | | | | | |
| NAME ADDRESS
1170 Rockville Pike; Rockville, Md. 20852 | | | | | | | | | | | |



#2ab, per call w/F.H. 2/6/84 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|--|---|--|---|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
CAROL T. KOWALCZYK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 10, 1983 | | | 2b. HOUR
12:16 P.M. | | | | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
MONTH DAY YEAR
NOV 3, 1913 | | 6 AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | 7 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10 CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1504 NOYES DRIVE | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SEWING | | 12b. KIND OF BUSINESS OR INDUSTRY
TEACHER | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1504 NOYES DRIVE 20910 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
AUDREY TORKOWSKI | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DOROTA WYZKOWSKA | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
181-10-2493 | | 17 INFORMANT
ADDRESS
CHESTER E. KOWALCZYK SAME AS 13 HUSBAND | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma
1830 DUE TO, OR AS A CONSEQUENCE OF
(b) Clear-cell carcinoma of Ovary
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
11/2 yrs | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
few mos | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 10/13, 19 83, to 12/7, 19 83, that (I) (we) last saw the deceased alive on 12/2, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
G. Lennard Gold, M.D. | | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/7/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
G. Lennard Gold, M.D. | | | | | 22e. ADDRESS
8630 Fenton St. #230 Silver Spring MD 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
12/10/83 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
FRANCIS J. COLLINS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Lohr | | | |

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | 20. DATE OF DEATH | | | 21. HOUR | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | 20. DATE OF DEATH | | | 21. HOUR | | |
| COBY AKBAR KRAUTHAMER | | | DEC. 22, 1983 | | | 9:30 A.M. | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | |
| MALE | | | WHITE | | | DEC 9 1976 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| WASH. D.C. | | | U.S.A. | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| COMAS, MD. | | | 24315 OLD HUNDRED PL. MD. | | | N/A | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | |
| MD. | | | MONTG. | | | COMAS | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. SOCIAL SECURITY NO. | | |
| GARY KRAUTHAMER | | | NANCY KADIAN | | | NONE | | |
| 17. INFORMANT | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>aspiration</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>congenital herpes simplex encephalitis 7 years</i> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 24315 OLD HUNDRED RD. COMAS, MARYLAND | | | | | | 10 minutes | | |
| 19a. DATE OF OPERATION | | | 19b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED | | |
| | | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | |
| WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>birth</i> 19 <i>September</i> 19 <i>79</i> that (I) (we) saw the deceased alive on <i>16 NOV 77</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | 22b. SIGNATURE | | | 22c. DATE SIGNED | | |
| | | | DEGREE | | | | | |
| | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | |
| DR. RUSSELL J. BUNAI | | | 4701 RANDOLPH RD. ROCKVILLE, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | |
| BURIAL | | | 12-23-83 | | | Norbeck Gardens | | |
| 24. FUNERAL DIRECTOR | | | 24b. DATE RECEIVED BY REGISTRAR | | | 24c. LOCATION | | |
| DANZANSKY-GOLDBERG MEM CHP, INC. | | | DEC 27 1983 | | | Olney; Montgomery; Maryland | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

24

10 minutes
12 minutes

10 minutes
12 minutes

10 minutes
12 minutes

10 minutes

10 minutes

10 minutes

10 minutes

10 minutes

10 minutes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Maria</i> | | | | 2a. DATE OF DEATH
MONTH DAY YEAR <i>12/30/83</i> | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR <i>Oct. 11, 1893</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>90</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Republic of West Germany</i> | | 7b. CITIZEN OR WHAT COUNTRY?
<i>West Germany</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery County, MD.</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>9100 Clewerwall Drive</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Own Home</i> | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Bethesda</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>George Roider</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Maria Scheungrab</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>No</i> | | | |
| 16b. SOCIAL SECURITY NO.
<i>226 82 6825</i> | | 17. INFORMANT
ADDRESS
<i>Berny J. Kreutz Son same as 13e</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral metastases</i>
<i>1629</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>Carcinoma of lung</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 mo</i>
<i>1 mo</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1973</i> , 19____, to <i>12/30/83</i> , 19____, that (I) (we) lost
saw the deceased alive on <i>12/16/83</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Jeremy V. Cooke</i> | | | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>12/30/83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Jeremy V. Cooke</i> | | | | 22e. ADDRESS
<i>10400 Conn. Ave. Kensington</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>Dec 31, 1983</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>St. Gabriel's Cem.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Potomac Maryland</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>Robert A. Pumphrey</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 9 1984</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Connel</i> | |
| Homes, P.A., Bethesda, Maryland | | | | | | | |

BP

ORIGINAL FILED
FBI - NEW YORK
JAN 10 1964



NEW YORK

20% COTTON



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY OCCURS, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. (PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE REMAINS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 4 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED IN THE VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMHM - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|-------------------------|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 33721 | |
| 1. DECEASED NAME
(TYPE OR PRINT) JEWEL S. KRONENBERG | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 7 1983 | | 2b. HOUR
M 2:38 | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR Mar. 14, 1887 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. 96 | | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 12 7 1983 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
Md. 20815 | | | | 13b. CITY OR TOWN
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5480 Wisconsin Avenue | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John D. Samelson | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha -- Somer | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
--- | | 17. INFORMANT
ADDRESS
Grace K. Colvin, 2727-29th St., NW, Wash., D.C. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(b) ---
DUE TO, OR AS A CONSEQUENCE OF
(c) ---
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Head Only | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
Ann M. Dixon | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 12-8-83 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | | 23b. DATE
12/12/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Oheb Shalom Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
NAME Joseph Gawler's Sons, Inc.
ADDRESS 5130 Wisconsin Ave., NW, Washington, D.C. 20016 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Gawler | | | |

BP
DHMH-16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed without delay in the death records of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified of this.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|------------------------|--|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) BERTHA KUNNLE | | | 2a DATE OF DEATH
MONTH DAY YEAR
12 17 1983 | | 2b HOUR
12³⁰ A.M. |
| 3 SEX
FEMALE | 4 RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
March 10, 1894 | | 6 AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10 CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Lutheran Home | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | 12b KIND OF BUSINESS OR INDUSTRY
unknown | | | |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Baltimore | | 13c. STREET ADDRESS
4128 Bedford Road, | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
John R. Lotz | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary E. Powers | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) no | |
| 16b. SOCIAL SECURITY NO.
214-74-1451 | | 17 INFORMANT
Rev. Richard Reichard | | ADDRESS
9701 Veirs Dr. Rockville Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4292 IMMEDIATE CAUSE (a) C.V.A.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>
NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from JANUARY 1980 , to 16 Dec 83 , 19 83 , that (I) (we) last saw the deceased alive on 16 December 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Thomas E. Dooley, M.D. | | DEGREE
M.D. | | 22c. DATE SIGNED
17 December 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas E. Dooley, M.D. | | 22e. ADDRESS
17904 Georgia Ave., Olney, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial | | 23b. DATE
Dec. 19, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | 24 FUNERAL DIRECTOR
NAME ADDRESS
The Hysong Company 1300 N St. N.W. Washington, D.C. | | | |
| 25a. DATE REC'D. BY REGISTRAR
DEC 27 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Conish | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EMERICK | | | 2a. DATE OF DEATH
MONTH Dec DAY 25 YEAR 1983 | | | 2b. HOUR
8¹⁰ A M | | | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 2 DAY 1 YEAR 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Hungary | | 7b. CITIZEN OF WHAT COUNTRY?
Israel | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Hebrew Home Greater Washington | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Pharmacist | | 12b. KIND OF BUSINESS OR INDUSTRY
----- | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET/ADDRESS
6111 MONTROSE -ROAD- | |
| 14. FATHER'S NAME
FIRST ALADAR MIDDLE LAST LAKNER | | | | 15. MOTHER'S MAIDEN NAME
FIRST ELENORA MIDDLE LAST BLOMNHAR | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) UNKNOWN (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
Nursing Home Chart ADDRESS | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiac Arrest**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 minutes

4409
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF
(b) **Atherosclerosis**
DUE TO, OR AS A CONSEQUENCE OF
(c)

5 yearsPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **None**

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/22 19 83 , to 12/25 19 83 , that (I) (we) last saw the deceased alive on 12/25 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Raymond Bass DEGREE MD | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12-25-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAYMOND BASS | | | | 22e. ADDRESS
3929 Ferrara R. Wheaton, Md 20906 | | | |

| | | | | | | | |
|--|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
12-26-83 | | 23c. NAME OF CEMETERY OR CREMATORY
JUDEAN MEM GDNS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
OLNEY MD. | |
|--|--|------------------------------|--|--|--|--|--|

| | | | |
|---|--|---|--|
| 24. FUNERAL DIRECTOR
NAME 1170 ROCKVILLE PK ADDRESS ROCKVILLE MD | | 25. DATE RECEIVED BY REGISTRAR DEC 28 1983 REGISTRAR'S SIGNATURE John L. Lakner | |
|---|--|---|--|

DANZANSKY-GOLDBERG MEM CHP INC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified through the coroner.

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

10

CHIEF

2014



MP

-50-

10/1/14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

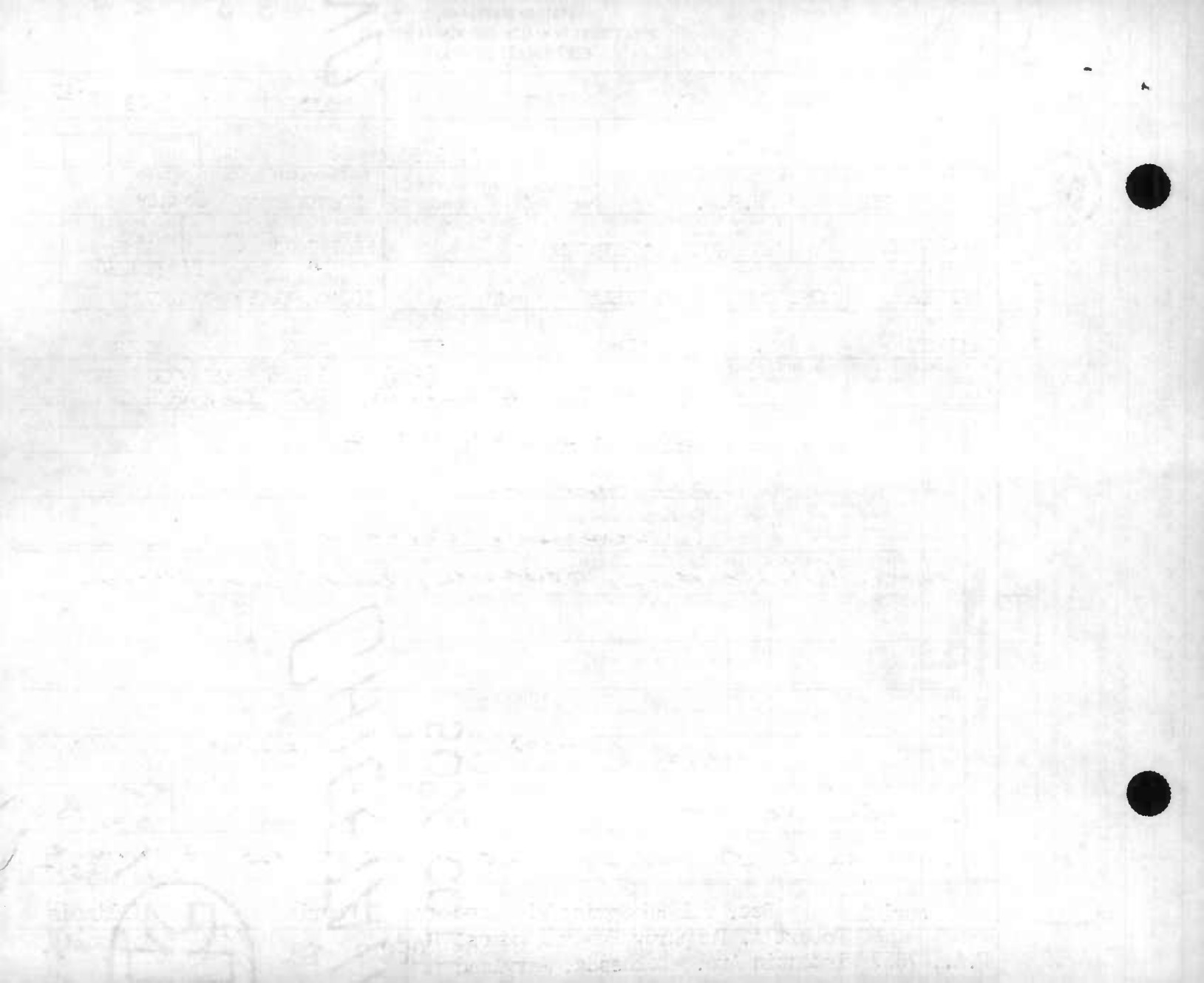
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARIE C. LANG | | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 2, 1983 | | | |
| 3. SEX
FEMALE | | | | 2b. HOUR
5:17 A M | | | |
| 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
DECEMBER 15, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
84 | | IF UNDER 1 YEAR
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY County MD | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ROCKVILLE NURSING HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | Zip: 20850 | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
13305 SOUTHWOOD DRIVE | | 14. FATHER'S NAME
FIRST MIDDLE LAST
LUDWIG F. DUHS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELSIE K. HESS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
342-28-4631D | | 17. INFORMANT (Son)
RAYMOND A. LANG | | ADDRESS
13305 SOUTHWOOD DRIVE
ROCKVILLE, MARYLAND 20850 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest</u>
4360
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Dehydration</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Cardiovascular Arrest</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.
<u>Myocardial Infarction, Dehydration, Arteriosclerosis</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-1-83</u> , 19____, to <u>12/2/83</u> , 19____, that (I) (we) lost
saw the deceased alive on <u>11/28/83</u> , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>D. Shumaker</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/2/83</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DOUGLAS R. SHUMAKER | | | | 22e. ADDRESS
615 W. MONT. AVE, ROCKVILLE
MD 20850 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 6, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Springdale Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Peoria Illinois | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | | | ADDRESS
Funeral Homes,
P.A., 7557 Wisconsin Ave., Bethesda, Maryland | | 25. DATE REC'D. BY REGISTRAR
DEC 7 1983 | |
| | | | | 25a. REGISTRAR'S SIGNATURE
<u>John J. Conner</u> | | | |

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|---|---|--|---|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Vernetta F. Lee | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec 9, 1983 | | | 2b. HOUR
8:35 AM | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
June 6, 1897 | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Michigan | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Pr. Geo. | | | 13c. CITY OR TOWN
Hy. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles A. Armbruster | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minnie Buer | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO.
577-28-2968 | | | 17. INFORMANT
7327-Old Columbia Rd.
Clifford L. Sincox Columbia, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia, anemia
4860
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12/1983 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)
die and abdominal aneurysm | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
— | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
— — — — — | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1980 19 12/9/83 19 12/9/83 , that (I) (we) lost saw the deceased alive on 12/8/83 19 12/8/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/19/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ASOTH LERAGUL, MD | | | | 22e. ADDRESS
4425 ARLINGTON RD, BETHESDA, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-13-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pr. Geo. Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Nalley's F.H. Inc. Mt. Rainier, Md. | | | | 25. BALTIMORE CITY OR COUNTY REGISTRAR'S SIGNATURE
DEC 16 1983 [Signature] | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 3.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) KRISTEN JACQUELYN LEFEGED | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 12-25-83 | | | |
| 3. SEX
FEMALE | | | | 2b. HOUR
10⁵⁹ M | | | |
| 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR 12 25 83 | | 6. AGE (IN YEARS LAST BIRTHDAY)
2 hours YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NONE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE MD. COUNTY Montg | | 13b. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS
20854 7709 Scotland Dr. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DOREEN CAROL LEFEGED | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
7650 | | 17. INFORMANT
ADDRESS
Doreen Lefeged (mother) SAME AS 13 | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Extreme immaturity
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 , to 19 , that (I) (we) lost
saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
A. Gebreselassie | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12-26-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Assefa Gebreselassie | | | | 22e. ADDRESS
Holy Cross Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
12-31-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Lincoln Park Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Montg Md. | |
| 24. FUNERAL DIRECTOR
NAME
George R. Snowden | | | | 25a. DATE REC'D. BY REGISTRAR (S) REGISTRAR'S SIGNATURE
IAN 6 1984 | | 25b. REGISTRAR'S SIGNATURE
John J. Gandy | |

BP



CHIEF

20% COTTON

12-21-05

1911

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Alexandra L. Leigh | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-16-83 | | | 2b. HOUR 6:03 PM | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Jan 27, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lativa | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physical Therapist | | 12b. KIND OF BUSINESS OR INDUSTRY Medical | |
| 13a. STATE Virginia | | 13b. COUNTY Fairfax | | 13c. CITY OR TOWN Alexandria | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6711 Wakefield Drive 99999 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Janis Kazuss | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zzanna Jaunzems | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 229-44-8748 | | 17. INFORMANT ADDRESS Mr. George Leigh, Husband Alex., Va. 22307. | | | | | |

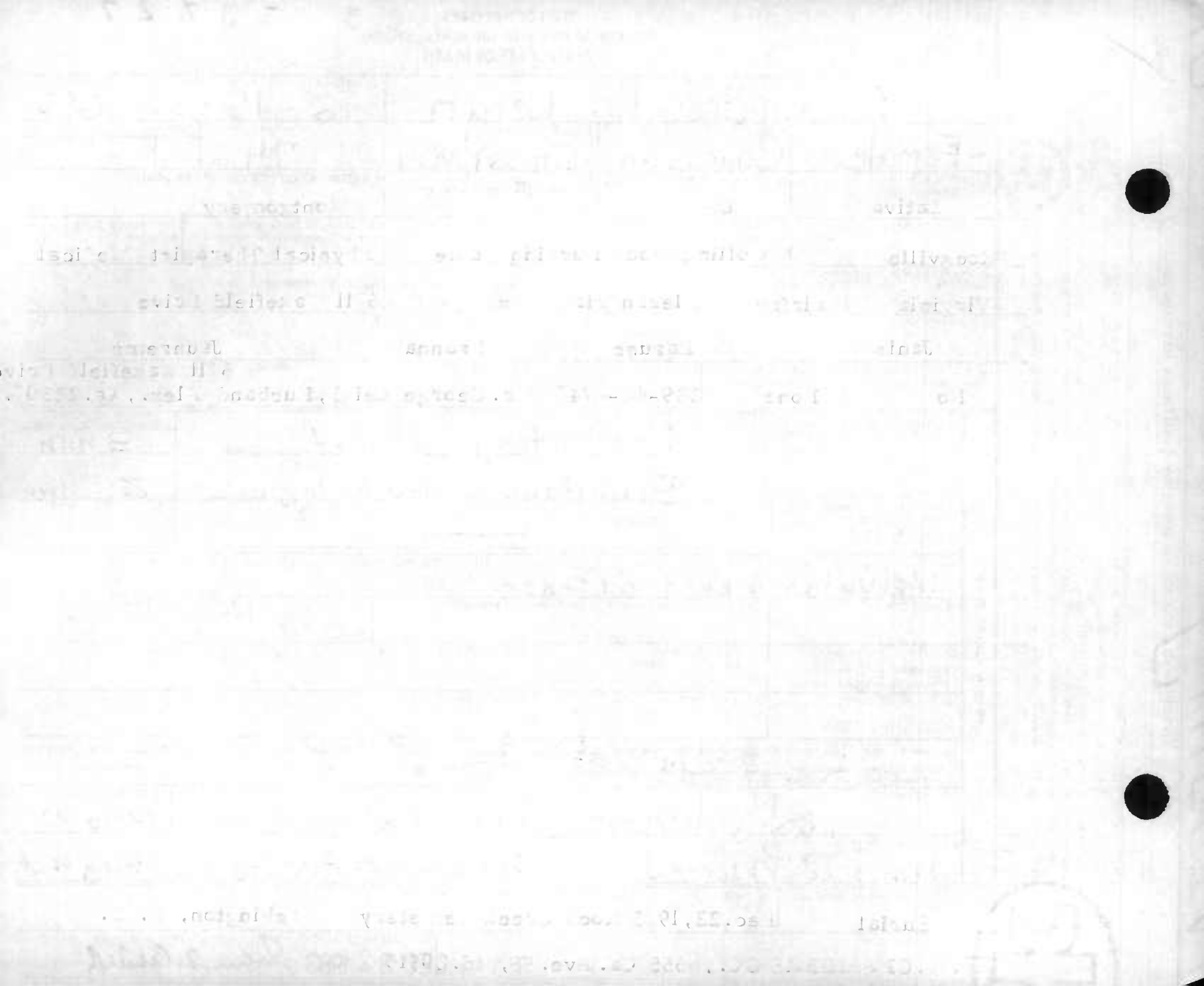
| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
3481 IMMEDIATE CAUSE (a) Respiratory arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 min |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Brain damage due to hypoxia | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

Valvular heart disease

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Dec 9, 1983 , to Dec 16, 1983 , that (1) we lost saw the deceased alive on Dec 15, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) we (1) did (1) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE James R. Moore Jr. | | | | DEGREE MD | | 22c. DATE SIGNED 12-16-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| James R. Moore Jr. | | | | 207 Brookes Ave Gaithersburg Md. | | | |

| | | | | | | | |
|--|--|--------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec. 22, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS W. W. CHAMBERS CO., 8655 Ga. Ave. SS, Md. | | | | 25a. DATE REC'D. BY REGISTRAR DEC 22 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

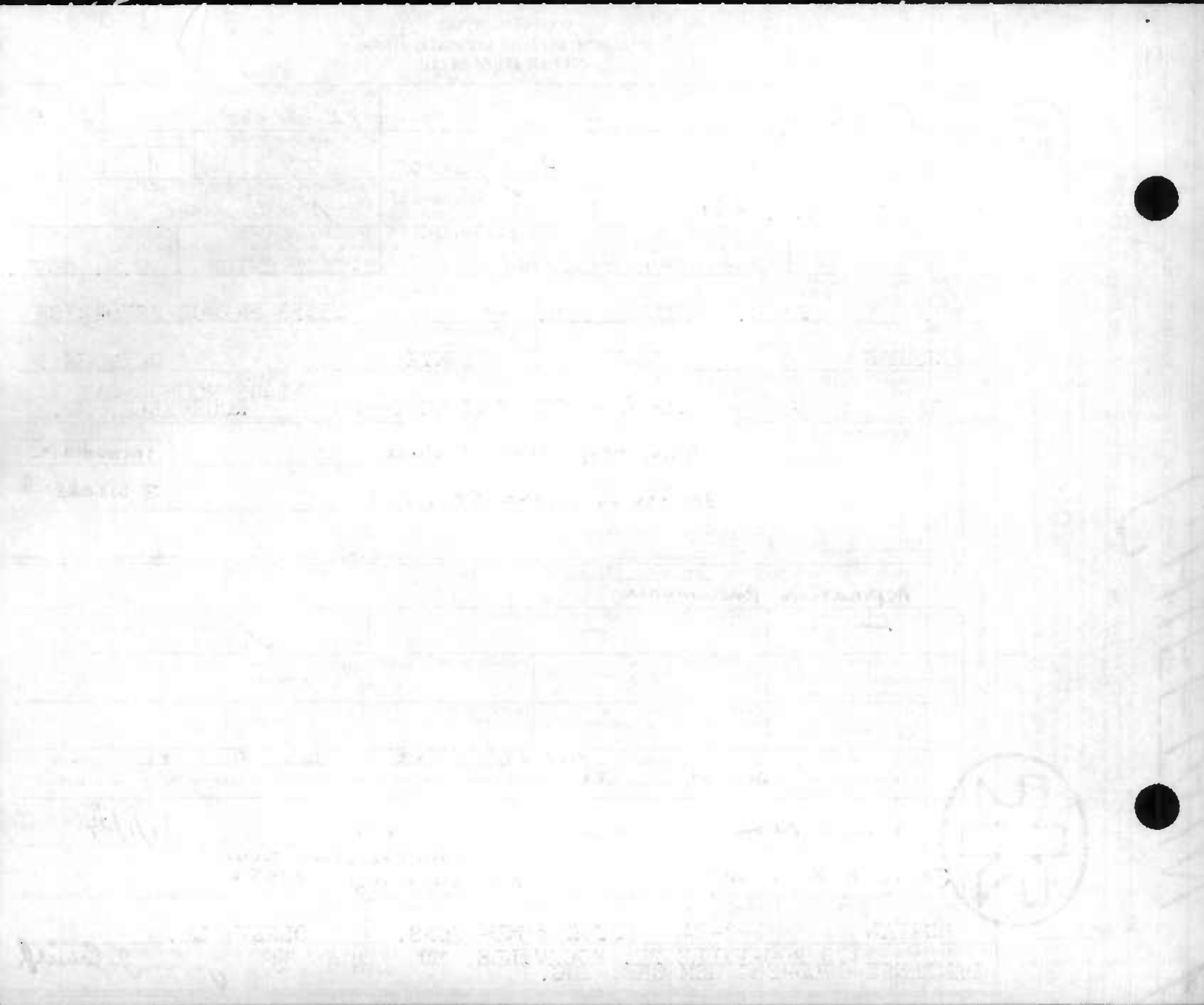
REG. NO.

| | | | | | |
|---|--|---|---|--------------------------------|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| I. DECEASED NAME
(TYPE OR PRINT) | | MONTH DAY YEAR | | MONTHS DAYS HOURS MIN. | |
| FIRST MIDDLE LAST
<i>Carl - Levy</i> | | <i>12 - 31 - 83</i> | | <i>6:13 P.M.</i> | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR
MONTHS DAYS | |
| <i>MALE</i> | <i>white</i> | MONTH DAY YEAR
<i>8 29 04</i> | <i>79</i> YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| <i>WASHINGTON, D.C.</i> | <i>USA.</i> | | <i>Montgomery</i> MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| <i>Bethesda</i> | <i>Suburban Hospital</i> | <i>PATENT CHIEF</i> | <i>U.S. GOVT.</i> | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| <i>MD.</i> | <i>MONTG.</i> | <i>SILVER SPR.</i> | <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/> | <i>15553 PRINCE FREDERICK</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | |
| <i>ABRAHAM</i> | <i>LEVY</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | |
| <i>NO</i> | | | <i>219-42-4275</i> | | |
| 17. INFORMANT | | | ADDRESS | | |
| <i>ALAN LEVY - SON</i> | | | <i>11403 HOUNDS WAY
ROCKVILLE, MD.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Respiratory Failure</i>
<i>4360</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Brainstem Stroke (C.V.A.)</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>3 weeks</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>3 weeks</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Aspiration Pneumonia</i> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | <i>YES</i> <input type="checkbox"/> <i>NO</i> <input checked="" type="checkbox"/> | <i>YES</i> <input type="checkbox"/> <i>NO</i> <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <i>19</i> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that the (this hospital) attended the deceased from <i>Nov 29, 1983</i> , to <i>Dec. 31, 1983</i> , that the (we) last saw the deceased alive on <i>Dec. 31, 1983</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED | | |
| <i>James A. Rossi</i> | <i>MD</i> | | <i>1/1/84</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | | | |
| <i>JAMES A. ROSSI MD</i> | <i>6111 EXECUTIVE BLVD.
ROCKVILLE, MD 20852</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| <i>BURIAL</i> | <i>1-2-84</i> | <i>JUDEAN MEM GDNS.</i> | <i>OLNEY, MD.</i> | | |
| 24. FUNERAL DIRECTOR | | | DATE REC'D. BY REGISTRAR | | |
| <i>170 ROCKVILLE PK., ROCKVILLE, MD</i> | | | <i>JAN 4 1984</i> | | |
| <i>DANZANSY-GOLDBERG MEM CHP, INC.</i> | | | <i>REGISTRAR'S SIGNATURE</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST
ELSA ANNA Levy | | 2a. DATE OF DEATH MONTH DAY YEAR
12-9-83 | | 2b. HOUR
7 P M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
March 14, 1887 | | 6. AGE (IN YEARS LAST BIRTHDAY)
96 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Germany | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Lab. Asst. (Ret) | | 12b. KIND OF BUSINESS OR INDUSTRY
Med. Lab. | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spg. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Mose Weyl | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Karewski | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> NO | | | |
| 16b. SOCIAL SECURITY NO.
235-14-6216D | | 17. INFORMANT ADDRESS
Albert Levy; 9702 Forest Glen Ct., SSpG, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrtine Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
days
days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypertension | | | | | | | |
| 19a. DATE OF OPERATION
4/8/60 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Hypertension | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-9-83 , to 12-10-83 , that (I) (we) lost saw the deceased alive on 12-10-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert J. Harper, M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
12/10/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ELSA J. HARTNER, M.D. | | | | 22e. ADDRESS
8808 HIDDEN HILL LD. - POTOMAC, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-11-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Garden | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church; Virginia | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Danzansky-Goldberg Chapel; 1170 Rockville Pike | | | | 25. DATE REC'D. BY REGISTRAR
DEC 12 1983 | | | |
| | | | | 26. REGISTRAR'S SIGNATURE
John J. Conner | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP

ELIZABETH A. COY

20% COTTON

WASHING MACHINE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FAY Marie LIDDICOAT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 8 83 | | | 2b. HOUR
0335A | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 11 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Canada | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
- | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Derwood | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
16522 Redland Rd. 20855 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Israel - Dagenais | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
- | | 17. INFORMANT
ADDRESS
16522 Redland Rd.
Howard Liddicoat Derwood, Md. 20855 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
1579
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Carcinoma of the esophagus</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
T HR
3 mos | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>Recurrent meningioma, post-op. x 3, & 4 hemiparesis, & 3rd nerve palsy.</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/7</u> to <u>11/24</u> , 19 <u>83</u> , that (I) (we) lost
saw the deceased alive on <u>12/7</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Ruben Cosca, M.D.</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/8/83</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>RUBEN COSCA, M.D.</u> | | | | | 22e. ADDRESS
<u>17529 REDLAND ROAD
DERWOOD, MD, 20855</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
12/11/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR
<u>Gartner Sandison F.H.</u> | | | | | 316 E. Diamond Ave.
Gaithersburg, Md. 20877 | | 25. DATE REC'D BY REGISTRAR
DEC 12 1983 | | | |
| 26. REGISTRAR'S SIGNATURE
<u>John J. Gault</u> | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|------------------------------|---|---|--|--------------------------------------|---|-----------------|---|------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| Joseph Lindworm | | | | | 12 13 83 | | | | | 8:13 PM | |
| 3. SEX | RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| male | caucasian | | 10 24 21 | | 42 | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| NY | U.S.A. | | | | Montgomery | | MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| Silver Spring | | Holy Cross Hospital | | | | Office Chief (Ret.) | | US Govt. | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | Montgomery | | Bethesda | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 8200 Stone Trail Drive | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | |
| Philip Lindworm | | | | Ethel (unknown) | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| Yes WW II | | | | 080-12-5566 | | Bethesda, Md.
Naomi Lindworm; 8200 Stone Trail Drive | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) UREMIA & renal failure
2028 DUE TO, OR AS A CONSEQUENCE OF
(b) Lymphomatous renal obstruction
DUE TO, OR AS A CONSEQUENCE OF
(c) malignant lymphoma | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 month
1 month | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
DIABETES; ARTERIOSCLEROTIC HEART DISEASE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | | | |
| 22a. I certify that (1) (the hospital) attended the deceased from
saw the deceased alive on December 13 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| JASON GELPER M.D. | | | | | | | | | | 12-13-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| JASON GELPER M.D. | | | | SP3 0 CAMERON STREET
SILVER SPRING, MD. 20910 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 12/16/1983 | | Beth David Cemetery | | Elmont, L.I., New York | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | 19 1983 | | | | John J. Connel | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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80% COTTON

11/11/11



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Harriet hipschultz</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>Dec 27, 1983</i> | | | 2b. HOUR
<i>5:30 P.M.</i> | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>Sept. 25, 1922</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>61</i> YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW JERSEY | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
DOWLED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery Co</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Holy Cross</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Service Rep. | | 12b. KIND OF BUSINESS OR INDUSTRY
C & P | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
<input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
412 E. Franklin Ave. 20901 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Albert Eisenberg | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Anna Wortzel | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT ADDRESS
Husband: Lionel Lipschultz same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>respiratory arrest</i>
<i>1729</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Metastatic melanoma</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>18 months</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/26/83</i> , 19____, to <i>12/27/83</i> , 19____, that (I) (we) last saw the deceased alive on <i>12/27/83</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Deborah B Goldberg</i> | | | DEGREE
<i>MD</i> | | | ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12/28/83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Deborah B Goldberg</i> | | | 22e. ADDRESS
<i>1106 spring St, Silver Spring Maryland</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Dec 29 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
King david | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church, Virginia | | |
| 24. FUNERAL DIRECTOR
NAME
Ives-Pearson F. H. Falls Church, Va. | | | ADDRESS
Falls Church, Virginia | | | DATE REGD. BY REGISTRAR AND REGISTRAR'S SIGNATURE
JAN 03 1984 <i>John J. Connel</i> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

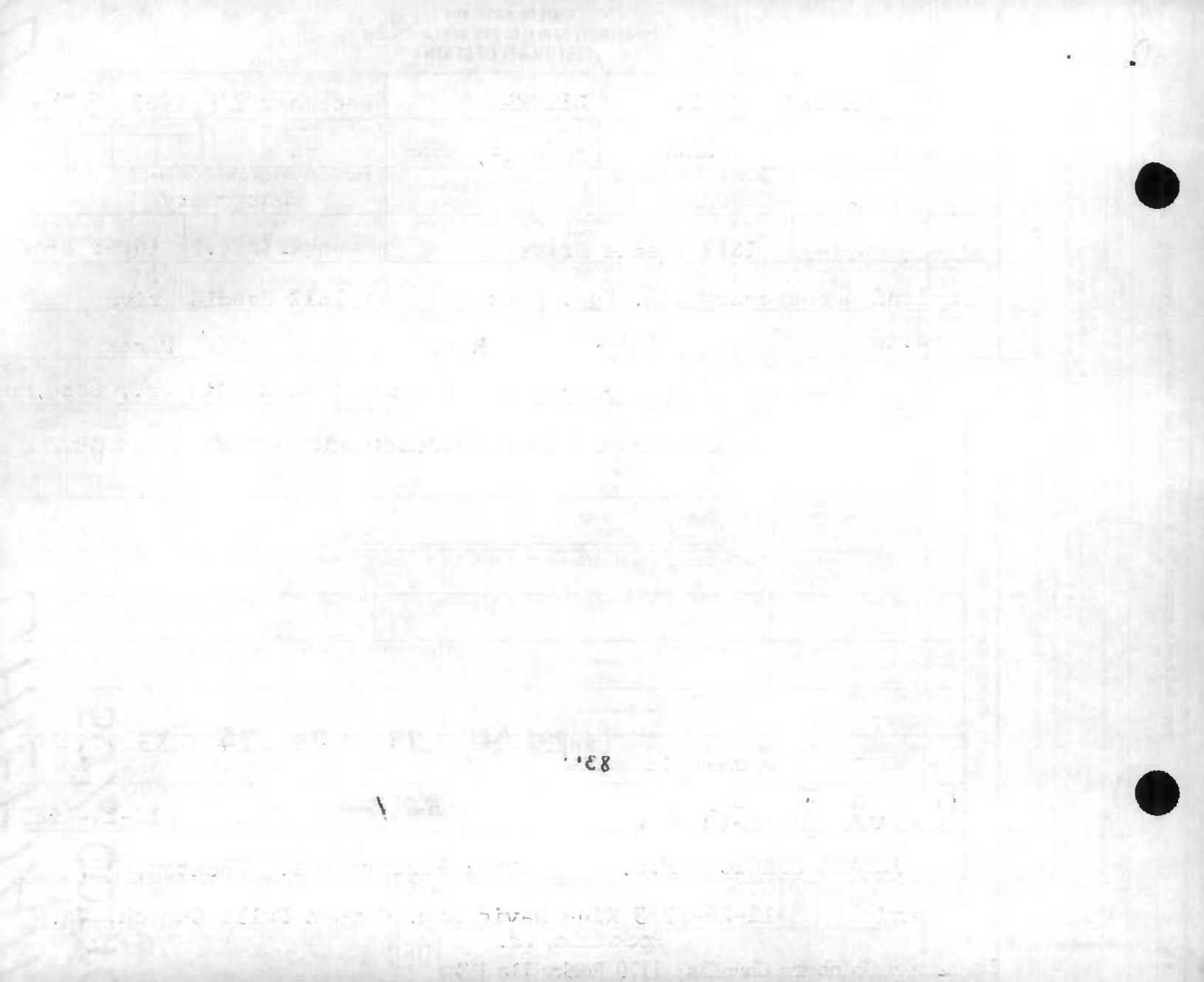
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST
MARTIN S. LITTMAN | | | | December 24 1983 | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
June 15, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1812 Reddie Drive | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Manager (Ret.) | | 12b. KIND OF BUSINESS OR INDUSTRY
Liquor Store | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spg. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
David Littman | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Rose Diner | | 13e. STREET ADDRESS
1812 Reddie Drive | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
578-20-4525 | | 17. INFORMANT ADDRESS
Eva Littman; 1812 Reddie Dr., SSpg, Md | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate with Metastases</u>
1850 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 years | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>approx July</u> 19 <u>77</u> , to <u>DEC 24</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>December 23</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22a. SIGNATURE
Israel Spector MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-24-1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ISRAEL SPECTOR, M.D. | | | | 22e. ADDRESS
12001 Ferrara Ave., Wheaton, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-26-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Garden Falls Church, Va. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Md. | |
| 24. FUNERAL DIRECTOR NAME
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 28 1983 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|--|---|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Lena F. Lokey | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 21, 1983 | | | 2b. HOUR
6:03 P.M. | | | | | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
November 15, 1890 | | 6 AGE (IN YEARS LAST BIRTHDAY)
93 | | 7 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Collingswood Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Cafeteria Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S.N. Yards | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
14000 Castle Blvd. #100 20904 | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
577-12-3747 | |
| 17 INFORMANT
Charles A. Nestor (Personal Representative) | | | ADDRESS See Item #13 | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4140 CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROTIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO-SCLEROSIS
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES YEARS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (the hospital) attended the deceased from June 83 to date 1983, that (I) (we) last saw the deceased alive on 12/21/83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | | |
| 22a. SIGNATURE
Thos B. Ward M.D. | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/21/83 | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
Thos B. Ward | | | 22d. ADDRESS
6116 Robinwood Bethesda, Md 20817 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
24 Dec 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, Prince George, Md | | | |
| 24. FUNERAL DIRECTOR
J. William Lee's Sons Company
300 Fourth St NE Washington, D.C. 20002 | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1984 | | 25b. REGISTRAR'S SIGNATURE
John J. Conish | | | |

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November 1, 1957

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United States

31 Aug 74

Director, U.S. Customs Service

John Edgar Hoover

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St. Louis, Mo., Jan. 1, 1883.

1. Officer Page's report, 11/25/52

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

33735

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Mary Louise Love | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 12 83 | | 2b. HOUR
6 ²⁵ AM | | | |
| 3. SEX
female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Mar. 19, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70
YRS. MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY CITY OR TOWN
Maryland Montgomery Silver Spring | | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS / ZIP CODE
1106 Briggs Chaney Rd. 20904 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Thornton Patton | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lola McKimney | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
ADDRESS
W. Ralph Love- husband- same as 13c | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lung Cancer</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchitis, Heart Failure, Bone mets</u>
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.
1629 | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 mo
22 months | |
| PART 2 (OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)) | | | | | | | | |
| 19a. DATE OF OPERATION
- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>4</u> 19 <u>83</u> to <u>12</u> 19 <u>83</u> , that (1) (we) last saw the deceased alive on <u>10/17</u> 19 <u>83</u> , and that (1) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<u>Peter Sherer</u> MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/12/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Peter B. Sherer, MD | | 22e. ADDRESS
3947 Ferrara Drive, Wheaton, Md. 20906 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Dec. 15, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hines/Rinaldi Funeral Home Sil. Spr. Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1983 | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Lohr</u> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in the funeral director's office. This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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REG. NO.

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 3 7 3 7

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Thomas C. MACKIE, Jr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
1 12 15 83 | | | 2b. HOUR
3:21 AM | |
| 3. SEX
M | | 4. RACE
CAUC. | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 13 30 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.J. | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTEGOMERY CO. MD. | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
AUDITOR | |
| 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Army | | 13a. STREET ADDRESS
12625 CHANLER LANE | | 13b. CITY OR TOWN
BOWIE | | 13c. STATE
MD. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Carswell Mackie, Sr. | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Catherine Sparrow | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
1954-1970 | | 17. INFORMANT
ADDRESS
Mrs. Elizabeth B. Mackie 12625 Chanler Lane Bowie, MD 20715 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) CORONARY ARTERY DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
16 DAYS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DEC 10 , 19 83 , to DEC 15 , 19 83 , that (I) (we) lost saw the deceased alive on DEC 14 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
James A. Roman | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-15-83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES A. ROMAN | | | | 22e. ADDRESS
9715 Medical Center Drive Rockville, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12-19-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Restland Memorial Park Hanover | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
New Jersey | |
| 24. FUNERAL DIRECTOR
NAME
Beall Funeral Home | | | | 16000 Annapolis Road
Bowie, Maryland 20715 | | 25a. DATE REG'D BY REGISTRAR
DEC 21 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. Smith | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked in item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE ETHEL LAST MADIGAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-22-83 | | 2b. HOUR
7:30 P.M. |
| 3. SEX
FEMALE | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
12 20 01 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Wheaton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | 12b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
PR. GEO. | 13c. CITY OR TOWN
BELTSVILLE | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PHILLIP H. WEBER | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELEANOR CRONIN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
577-07-7912 | | 17. INFORMANT
ADDRESS
WILLIAM F. MADIGAN 11301 BELTSVILLE, MD.
MONTGOMERY RD. 20705 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4275

IMMEDIATE CAUSE (a) Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

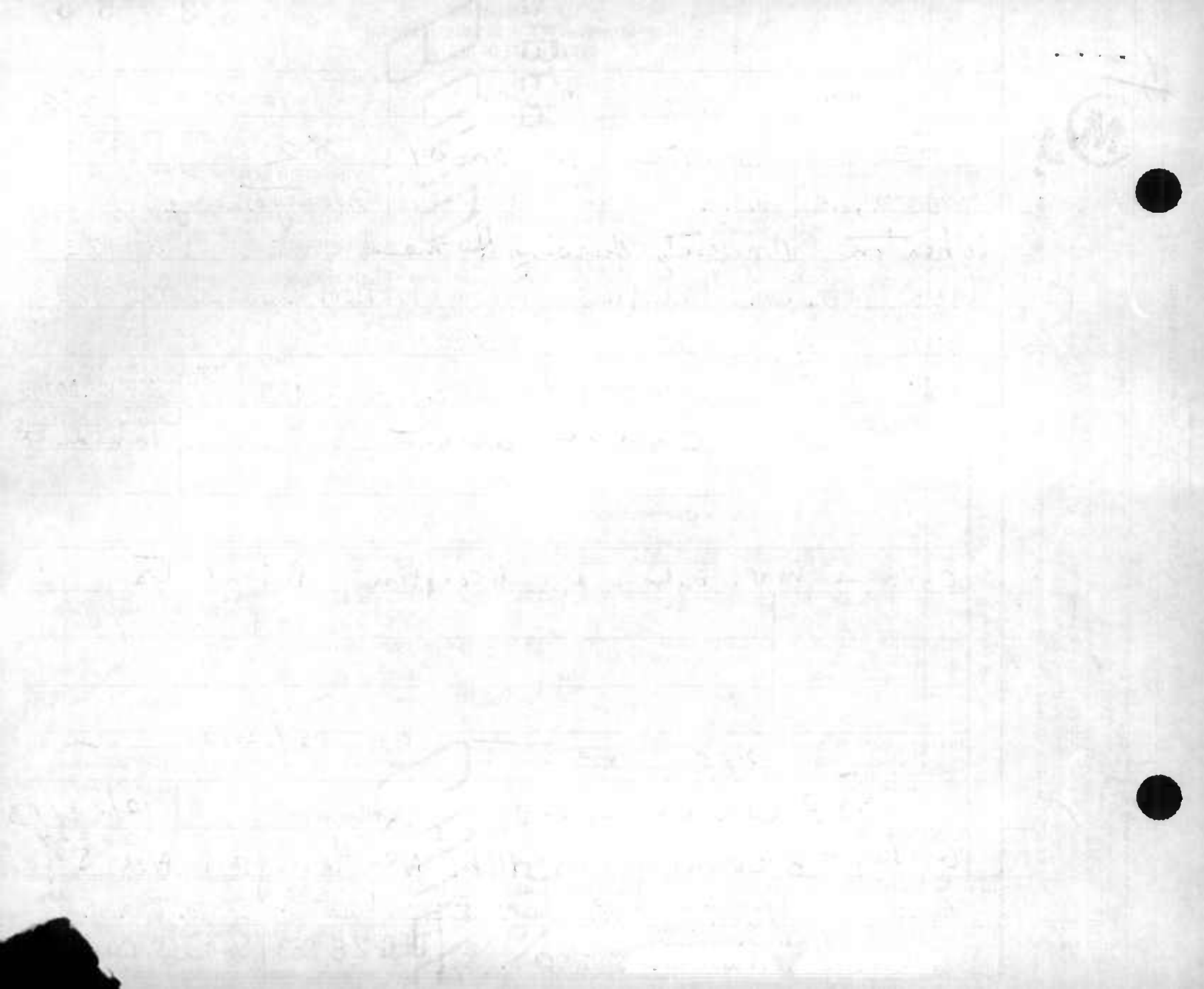
Immediate

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

Chronic Malabsorption, Diabetes

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/18/83, 1983, to 12/22/83, 1983, that (we) last saw the deceased alive on 12/18/83, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | |
| 22b. SIGNATURE
GB Cushman MD | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
12/23/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gilbert B. Cushman, MD | | 22e. ADDRESS
11161 New Hampshire Ave. S.S. 20909 | |

| | | | |
|---|-----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
12/27/83 | 23c. NAME OF CEMETERY OR CREMATORY
FT. LINCOLN CEMETERY | 23d. LOCATION
(CITY OR TOWN) COUNTY STATE
BRENTWOOD PR. GEO. MD. |
| 24. FUNERAL DIRECTOR
NAME FRANCIS J. COLLINS
500 UNIVERSITY BLVD. W. SILVER SPRING, MD. 20901 | | 25. DATE REC'D. BY REGISTRAR
DEC 28 1983 | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Gaoracette | | FIRST
MANN | | LAST
Heimer | | 20. DATE OF DEATH
MONTH DAY YEAR
December 4, 1983 | | 2b. HOUR
12:50 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH YEAR
2-7-80 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Springs | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sylvan Manor HealthCare Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
2700 BARKER Ave S.S. 20901 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Van Horn | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Louise UNK | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
223-28-8360 | | 17. INFORMANT
Louise Boscoe | |
| 16c. ADDRESS
736 GILFORD ST
Silver Spring 20901 | | | | | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4408
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 1982 to Dec 4, 1983, that (I) (we) last saw the deceased alive on 10-28-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Edward J. Richards | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-4-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EDWARD J. RICHARDS | | | | 22e. ADDRESS
10301 Georgia Ave S.S. 20906 | | | |

| | | | | | | | |
|--|--|--------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
Dec 7, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Chambers Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rivendale P. Geo Md | |
| 24. FUNERAL DIRECTOR
(NAME)
W.W. Chambers Co, 8655 Georgia Ave, S.S. Md. 20901 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 9 8 1983 | | 25b. REGISTRAR'S SIGNATURE
James L. Connel | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

1. The first part of the report is a summary of the work done during the past year. It includes a list of the projects which have been completed, and a description of the progress made on the projects which are still in progress. The second part of the report is a detailed account of the work done on each of the projects. It includes a description of the methods used, and a discussion of the results obtained. The third part of the report is a summary of the conclusions reached, and a list of the recommendations made.

2. The first project was the design and construction of a new type of engine. The engine was designed to be more efficient than the existing engines, and to be able to operate at higher speeds. The design was completed in the first half of the year, and the construction was completed in the second half. The engine was tested, and the results showed that it was indeed more efficient than the existing engines, and was able to operate at higher speeds.

3. The second project was the design and construction of a new type of machine. The machine was designed to be able to process a larger amount of material than the existing machines, and to be able to operate at higher speeds. The design was completed in the first half of the year, and the construction was completed in the second half. The machine was tested, and the results showed that it was indeed able to process a larger amount of material than the existing machines, and was able to operate at higher speeds.

4. The third project was the design and construction of a new type of machine. The machine was designed to be able to process a larger amount of material than the existing machines, and to be able to operate at higher speeds. The design was completed in the first half of the year, and the construction was completed in the second half. The machine was tested, and the results showed that it was indeed able to process a larger amount of material than the existing machines, and was able to operate at higher speeds.

5. The fourth project was the design and construction of a new type of machine. The machine was designed to be able to process a larger amount of material than the existing machines, and to be able to operate at higher speeds. The design was completed in the first half of the year, and the construction was completed in the second half. The machine was tested, and the results showed that it was indeed able to process a larger amount of material than the existing machines, and was able to operate at higher speeds.

6. The fifth project was the design and construction of a new type of machine. The machine was designed to be able to process a larger amount of material than the existing machines, and to be able to operate at higher speeds. The design was completed in the first half of the year, and the construction was completed in the second half. The machine was tested, and the results showed that it was indeed able to process a larger amount of material than the existing machines, and was able to operate at higher speeds.

7. The sixth project was the design and construction of a new type of machine. The machine was designed to be able to process a larger amount of material than the existing machines, and to be able to operate at higher speeds. The design was completed in the first half of the year, and the construction was completed in the second half. The machine was tested, and the results showed that it was indeed able to process a larger amount of material than the existing machines, and was able to operate at higher speeds.

8. The seventh project was the design and construction of a new type of machine. The machine was designed to be able to process a larger amount of material than the existing machines, and to be able to operate at higher speeds. The design was completed in the first half of the year, and the construction was completed in the second half. The machine was tested, and the results showed that it was indeed able to process a larger amount of material than the existing machines, and was able to operate at higher speeds.

9. The eighth project was the design and construction of a new type of machine. The machine was designed to be able to process a larger amount of material than the existing machines, and to be able to operate at higher speeds. The design was completed in the first half of the year, and the construction was completed in the second half. The machine was tested, and the results showed that it was indeed able to process a larger amount of material than the existing machines, and was able to operate at higher speeds.

10. The ninth project was the design and construction of a new type of machine. The machine was designed to be able to process a larger amount of material than the existing machines, and to be able to operate at higher speeds. The design was completed in the first half of the year, and the construction was completed in the second half. The machine was tested, and the results showed that it was indeed able to process a larger amount of material than the existing machines, and was able to operate at higher speeds.

11. The tenth project was the design and construction of a new type of machine. The machine was designed to be able to process a larger amount of material than the existing machines, and to be able to operate at higher speeds. The design was completed in the first half of the year, and the construction was completed in the second half. The machine was tested, and the results showed that it was indeed able to process a larger amount of material than the existing machines, and was able to operate at higher speeds.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
|---|---|---|--------------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Lucy R. Manning | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 6, 1983 | | 2b. HOUR
MIN.
1:00PM | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 1, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87
MONTHS DAYS HOURS MIN.
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
AR | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Lawyer | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD 20862 | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Brinklow | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Isaac Rains | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lucy O'Neal | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
217-44-3655 | | 17. INFORMANT
ADDRESS
NY 10510 | |
| 18. CAUSE OF DEATH (Enter only one cause per item (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
5621
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Upper Gastric Hemorrhage
(c) Post-op Sigmoid Colon Perforation
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
Strain | | | | | |
| 19a. DATE OF OPERATION
11/25/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Repaired Sigmoid Diverticulitis | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 25, 1983 , to Dec. 6, 1983 , that (I) (we) lost saw the deceased alive on DEC 6, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Robert A. Barnett, M.D. | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
DEC. 7, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT A. BARNETT MD | | 22e. ADDRESS
3906 Bee Pra Ed - Wheaton md 20902 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/9/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodside Cemetery | |
| 23d. LOCATION
CITY OR TOWN
Brinklow, MD | | COUNTY
Montgomery | | STATE
MD | |
| 24. FUNERAL DIRECTOR
NAME
Joseph Gawler's Sons, Inc. | | ADDRESS
5130 Wosc. Ave. N.W. Wash., DC 20016 | | 25a. DATE REC'D. BY REGISTRAR
DEC 12 1983 | |
| 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | | | |

2020 MON. 10.11.2020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | | | | |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MIRIAM MARGOLIS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 21 83 2b. HOUR 8:28 AM | | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH
MONTH DAY YEAR 6 30 01 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY HOME | |
| 13a. STATE MD. | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN ROCKVILLE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 11420 STRAND DR. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST DON MORDECHAI ADAM | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST ITA UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 577-36-4809 | | 17. INFORMANT SOLOMON L. MARGOLIS | | ADDRESS 11112 ARROYO DR. ROCKVILLE, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ACUTE RENAL FAILURE 2 weeks
(c) ACUTE MYOCARDIAL INFARCT 2 weeks | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-6 , 19 83 , to 12-21 , 19 83 , that (I) (we) lost saw the deceased alive on 12-20 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Stephen H. Henman DEGREE MD | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12-21-83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN HENMAN MD | | | | | 22e. ADDRESS 6246 MONTROSE RD. ROCKVILLE, MD 20852 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12-22-83 | | 23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM GDN FALLS CHURCH, VA. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR 1170 ROCKVILLE PK. ROCKVILLE MD DANZANSKY-GOLDBERG MEM CHP, INC. | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 27 1983 | | 25b. REGISTRAR'S SIGNATURE See 20852 | | |

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

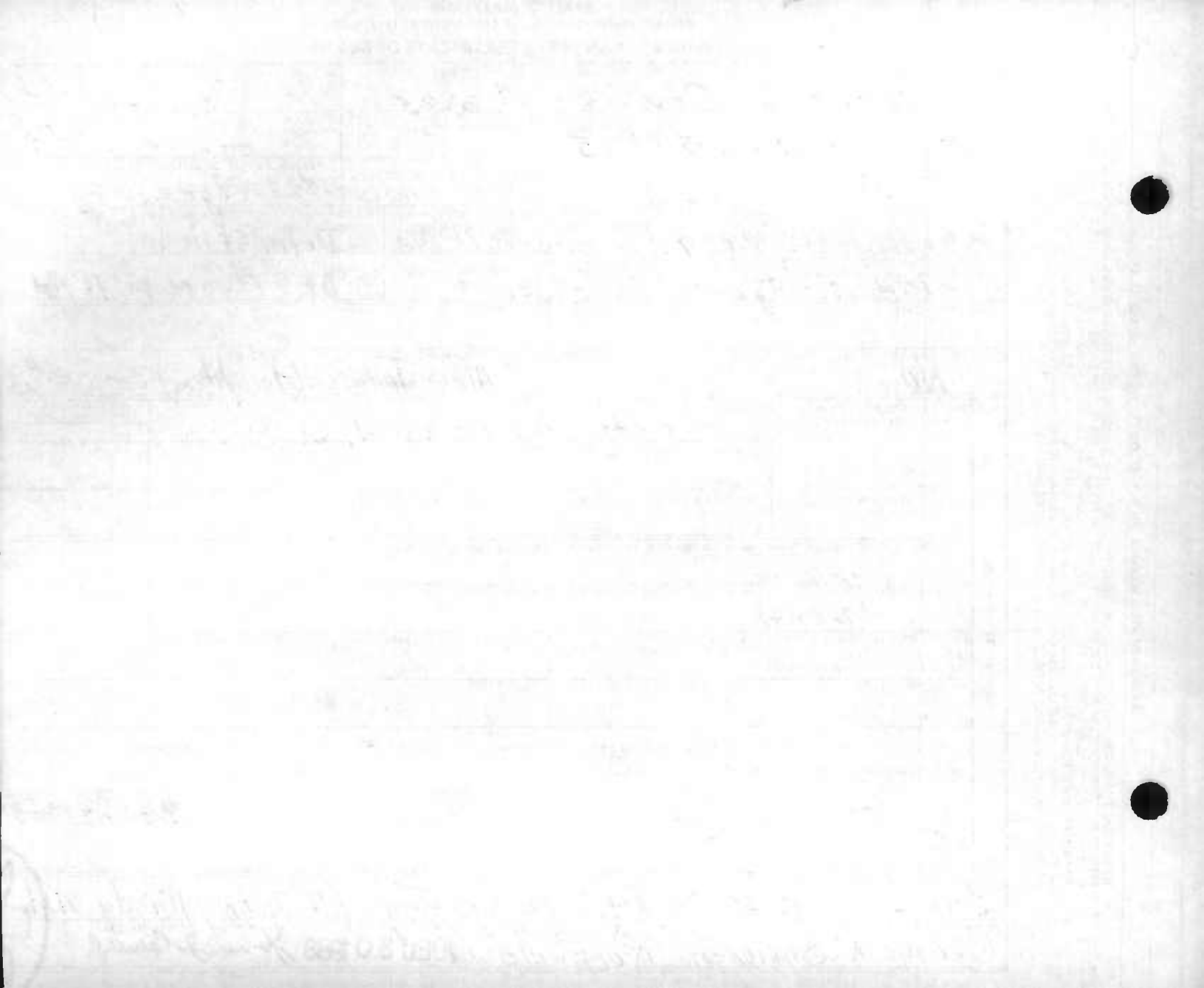
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|--------------------|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Bertha Corolina Mayes</i> | | | 2a. DATE KNOWN OF DEATH ESTIMATED <i>Dec 24 1983</i> | | | 2b. HOUR <i>8:45</i> | | |
| 3. SEX <i>F</i> | 4. RACE <i>Blk</i> | 5. DATE OF BIRTH <i>March 15 1925</i> | 6. AGE (IN YEARS LAST BIRTHDAY) <i>58</i> YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD <i>Dec 24 1983</i> | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD. | | |
| 10. CITY OR TOWN OF DEATH <i>Kennington</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>4007 Plymcr Mill Rd</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Domestic</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE <i>Md</i> | | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Kennington</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | 13e. STREET ADDRESS <i>4007 Plymcr Mill Rd</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i> | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>ALMA JOHNSON (daughter) SAME AS #13</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Myocardial Inf</i>
4291
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>None</i> | | | | | | | | |
| 19a. DATE OF OPERATION <i>None</i> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE <i>John Rogers</i> | | | TITLE (SPECIFY) M.D. <i>Dip</i> | | | MEDICAL EXAMINER DATE SIGNED <i>Dec 24 1983</i> | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>12-29-83</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Cemetery</i> | | 23d. LOCATION CITY OR TOWN STATE <i>Mt. Zion Montg Md.</i> | | |
| 24. FUNERAL DIRECTOR NAME <i>George R. Snowden</i> | | | ADDRESS <i>246 N. WASH. ST. Rockville, Md</i> | | DATE REC'D. BY REGISTRAR <i>DEC 30 1983</i> | | REGISTRAR'S SIGNATURE <i>John J. Gough</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EDWARD Leroy McALEER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 10 83 | | 2b. HOUR
4 30 AM | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 12, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
District of Columbia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Carriage Hill Nursing Center | | 12. USUAL OCCUPATION
(TYPE OR WORK FOR MOST OF WORKING YEARS)
Chairman of Board | | 12b. KIND OF BUSINESS OR INDUSTRY
Savings & Loan | |
| 13a. STATE
Maryland | 13b. COUNTY
Anne Arundel | 13c. CITY OR TOWN
Edgewater | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
222 Riverside Road 21037 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward McAleer | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Manifold | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
578-03-3895 | | 17. INFORMANT
ADDRESS
Evelyn Lohr, 148 Monroe St., Rockville, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) generalized arteriosclerosis
4409
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 yrs | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
chronic anemia Parkinsonism | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22. I certify that (I) (this hospital) attended the deceased from FEB. 19 80 to 12-10 83 , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 11-29 83 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death. | | | | | | |
| 23a. SIGNATURE
G. Sengstack | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 23c. DATE SIGNED
12-10-83 |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)
G. Sengstack | | 23d. ADDRESS
9241 Columbia Blvd., Silver Spring, Md. | | | | |
| 23e. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23f. DATE
12-13-83 | | 23g. NAME OF CEMETERY OR CREMATORY
Rock Creek | | 23h. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons | | ADDRESS
5130 Wis. Ave. N.W. | | 25. DATE REC'D. BY REGISTRAR
DEC 15 1983 | | |
| 24b. REGISTRAR'S SIGNATURE
John J. Carver | | 25b. REGISTRAR'S SIGNATURE | | | | |

75015

Washington, D.C.

• F. OVA. BIRD. OER

• • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Division of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2b. HQR | | | |
| JAMES J. McAuliffe | | | | 12 20 83 4 ⁰⁰ P.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | Caucasian | | 4 13 16 | | 67 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Washington DC | | U.S.A. | | | | Montgomery County MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | | Holy Cross Hospital | | D.C. Police Dept | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| md. | | Montgomery | | Sil Spr | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | | | |
| James John McAuliffe | | Nellie Flanagan | | 323 Branch Drive 20901 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | 578 05 7131 | | Louise McAuliffe Wife Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
4149
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Multiple Cardiac arrhythmias</u>
(c) <u>Coronary artery disease</u>
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Immediate</u>
<u>3 weeks</u>
<u>Long standing</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Anoxic Brain Damage</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| — | | — | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| <input type="checkbox"/> | | HOUR A.M. MONTH DAY YEAR
P.M. — 19 | | — | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | — | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/3</u> 19 <u>83</u> , to <u>12/20</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/20</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| <u>In Paul Kretz</u> | | | | MD | | 12-20-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| <u>Dr Paul Kretz</u> | | | | <u>1109 Spring St Silver Spring 20901</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | Dec. 23, 1983 | | Cedar Hill Cemetery | | Suitland Pr. Geo. Md. | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REG'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME Francis J. Collins ADDRESS | | | | DEC 28 1983 | | <u>John J. Collins</u> | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|--|---|---|--|--|-------------------------------------|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) BERTHA H. McCABE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 17, 1983 | | | 2b. HOUR
1200 P.M. | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 31, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Illinois | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Potomac | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Albert Reimer | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha Strelow | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
324-01-9713 | | 17. INFORMANT
ADDRESS
Betty Jean Topercer, same as #13 | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4409

IMMEDIATE CAUSE (a)

Cardiogenic shock

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

generalized atherosclerosis

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

acute renal failure

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

48+ hrs.

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-15 , 19 80 , to 12-17 , 19 83 , that (I) (we) last
saw the deceased alive on 12-17 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Donald C. Bucy | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/17/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Donald C. Bucy MD | | 22e. ADDRESS
809 Veins Mill Rd Rockville, MD | | | | | |

| | | | | | | | |
|--|--|----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
Dec. 21 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Queen of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hillside, Illinois | |
| 24. FUNERAL DIRECTOR
NAME Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical professional must be notified at once.

1. The first part of the paper is devoted to a discussion of the

general properties of the system of equations (1) and (2).

2. In the second part we consider the case of a homogeneous

system of equations (1) and (2) and show that the

solution is unique and depends continuously on the

data. 3. In the third part we consider the case of a

non-homogeneous system of equations (1) and (2) and

show that the solution is unique and depends continuously

on the data. 4. In the fourth part we consider the case of a

system of equations (1) and (2) with boundary conditions

and show that the solution is unique and depends continuously

on the data. 5. In the fifth part we consider the case of a

system of equations (1) and (2) with initial conditions

and show that the solution is unique and depends continuously

on the data. 6. In the sixth part we consider the case of a

system of equations (1) and (2) with mixed boundary

conditions and show that the solution is unique and depends

continuously on the data. 7. In the seventh part we

Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The attending physician and completely filled in this certificate should be detached for use on the burial permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 3 3 4 6

| | | | | | |
|--|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 3. SEX | | 4. RACE | |
| ANNA LOIS | | FEMALE | | BLACK | |
| 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| JUNE 25 1926 | | 57 YRS | | MONTGOMERY COUNTY MD | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 9. CITIZEN OF WHAT COUNTRY? | | 10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | |
| N.C. | | USA | | SLIGO GARDEN NURSING HOME | |
| 11. CITY OR TOWN OF DEATH | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 13. KIND OF BUSINESS OR INDUSTRY | |
| TOKOMA PARK | | None | | NONE | |
| 14. STATE | | 15. COUNTY | | 16. CITY OR TOWN | |
| M.D. | | Forrestville | | 7611 Mane Lane Forestville, MD | |
| 17. FATHER'S NAME (FIRST MIDDLE LAST) | | 18. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | 19. INFORMANT | |
| Joe Mc Clain | | Hattie Saddler | | Odell McClain (Bro) | |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES? (ES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 21. SOCIAL SECURITY NO. | | 22. ADDRESS | |
| No | | UNK | | Washington, D.C. | |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 24. IMMEDIATE CAUSE (a) | | 25. DUE TO, OR AS A CONSEQUENCE OF (b) | |
| 1539 | | Carcinomatosis | | Carcinoma of the Colon | |
| 26. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | 27. DATE OF OPERATION | | 28. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | | |
| 29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 32. INJURY OCCURRED (IF EITHER NOTIFY MEDICAL EXAMINER) | | 33. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 34. LOCATION (CITY OR TOWN COUNTY STATE) | |
| WITHE NOT WORK AT WORK | | | | | |
| 35. I certify that (I) (this hospital) attended the deceased from | | 36. DATE SIGNED | | 37. DATE REC'D. BY REGISTRAR | |
| 12/16 19 83 | | 12-19-83 | | DEC 29 1983 | |
| 38. SIGNATURE | | 39. PHYSICIAN'S NAME (TYPE OR PRINT) | | 40. ADDRESS | |
| [Signature] | | DR. MARK LI | | 1721 UNIVERSITY BLVD WHEATON MD. | |
| 41. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 42. DATE | | 43. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 12/23/83 | | Md National Memorial Park | |
| 44. FUNERAL DIRECTOR | | 45. DATE REC'D. BY REGISTRAR | | 46. REGISTRAR'S SIGNATURE | |
| Johnson + Jenkins | | DEC 29 1983 | | John J. Carver | |



RECEIVED
FEB 10 1953
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

Forrestville
Loc to Blair
Glen Station (no 328 17th St, W.D.
Washington, D.C.
Snyder

43315-10710

DEC 2 9 1953
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|-------------------------|--|--|---|---|---|---|--|--------------------------------|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Violet Kellogg McCune | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 13 1983 | | 2b. HOUR A | | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR 5 1 1964 | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS. 19 | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | 8. IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD 12 13 1983 | | 2d. HOUR 11⁴⁰ P | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY | | | | | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6012 KENNEDY DR | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Physician | | 12b. KIND OF BUSINESS OR INDUSTRY
Medicine | | | |
| 13a. STATE
MD 20815 | | 13b. CITY OR TOWN
MONTGOMERY | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
6012 KENNEDY DR | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
STANLEY | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Leary | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT
ADDRESS
Susan K. McCune, 5101 River Rd., Chevy Chase, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
BLUDE | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
— | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR A P.M. 12 13 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
COLLAPSED AT HOME | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
HOME | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
6012 KENNEDY DR KENWOOD MONT MD | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
Francis C. Mayo | | | TITLE (SPECIFY)
Dept | | M.D. | | MEDICAL EXAMINER | | DATE SIGNED
12/14/83 | | |
| EXAMINER'S NAME (TYPE OR PRINT)
FRANCIS C. MAYO | | | ADDRESS
5200 Wisconsin Ave Bethesda MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/16/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Culpeper National Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Culpeper Virginia | | | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc.
ADDRESS
5130 Wisc. Ave., N.W. Wash., D.C. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 20 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Gail | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as (a), (b) shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

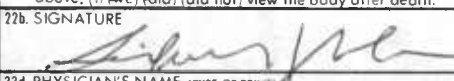

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Julia W. McFadden</u> | | | | | 2a. DATE OF DEATH
MONTH <u>12</u> - DAY <u>18</u> - YEAR <u>83</u>
2b. HOUR <u>6:00</u> P.M. | | | | | |
| 3. SEX
<u>FEMALE</u> | | 4. RACE
<u>WHITE</u> | | 5. DATE OF BIRTH
MONTH <u>JULY</u> DAY <u>24</u> , YEAR <u>1885</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>98</u> YRS | | 7. IF UNDER 1 YEAR
MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN. | | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Maryland</u> | | 8b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery County</u> MD. | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Rockville</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>National Lutheran Home</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Homemaker</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>at home</u> | | |
| 13a. STATE <u>Maryland</u> | | | | | 13b. COUNTY <u>Baltimore</u> | | 13c. CITY OR TOWN <u>Baltimore</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST <u>Christian</u> MIDDLE <u></u> LAST <u>Kalter</u> | | | | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Elizabeth</u> MIDDLE <u></u> LAST <u>Weikert</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <u>no</u> | | | | | 16b. SOCIAL SECURITY NO.
<u>212-07-9377D</u> | | 17. INFORMANT
ADDRESS <u>Rev. Richard Reichard 9701 Veirs Dr. Rockville Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
<u>5990</u> IMMEDIATE CAUSE (a) <u>Clinical Septicemia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Urinary Tract Infection</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M.</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 1</u> , 19 <u>82</u> , to <u>18 Dec</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>19 Dec</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Thomas E. Dooley, MD</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>12-18-83</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Thomas E. Dooley, M.D.</u> | | | | | 22e. ADDRESS
<u>9701 Veirs Road
Rockville, Md 20850</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>December 21, 1983</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Loudon Park Cemetery</u> | | | 23d. LOCATION
CITY OR TOWN <u>Baltimore</u> COUNTY <u>Maryland</u> STATE <u></u> | | | |
| 24. FUNERAL DIRECTOR
NAME <u>The Hysong Company</u> ADDRESS <u>1300 N St. N.W. Wash. D.C.</u> | | | | | DATE REC'D BY REGISTRAR <u>DEC 27 1983</u> REGISTRAR'S SIGNATURE <u>John L. Connelley</u> | | | | | |

BP _____

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|--|---|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Dorothy Virginia McGraw | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 8, 1983 | | | 2b. HOUR
12:52p M | | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 7 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
MONTHS DAYS HOURS MIN.
69 YRS | | 7. IF UNDER 1 YEAR
IF UNDER 24 HRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
301 Russell Ave. 20879 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Homer Davis | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Edith Estelle Morrison | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
235-56-1297 | | 17. INFORMANT
ADDRESS
James J. McGraw, Son,
Idamay, West Virginia | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) Ventricular tachycardia
DUE TO, OR AS A CONSEQUENCE OF
(b) Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) Coronary heart disease | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
24 hrs.
2 days
years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Diabetes, Rheumatoid Arthritis, several CVA's | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 24 , 19 75 , to Dec 8 , 19 83 , that (I) (we) lost
saw the deceased alive on Dec 8 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
 | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Dec. 8, 1983 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Sidney J. Cohen, M.D. | | | 22e. ADDRESS
121 Congressional Lane Suite 402
Rockville, Maryland | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 12, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Clarksburg West Virginia | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes,
P.A., Rockville, Maryland | | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1983 | | | | | | | 25b. REGISTRAR'S SIGNATURE
 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|---|-------------------|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| JAMES JOSEPH MCNALLY | | | | | 12/12/83 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) |
| MALE | | WHITE | | 08 TH 05 TH 19 TH 12 | | 71 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| NEW YORK | | U.S.A. | | | | MONTGOMERY CO. MD. |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) |
| SILVER SPRING | | HOLY CROSS HOSPITAL | | | | OFFICE MANAGER |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? |
| MARYLAND | | MONTGOMERY | | SILVER SPRING | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS / ZIP CODE | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 1014 SO. BELGRADE ROAD 20902 | | |
| PATRICK | | MCNALLY | | TERESA | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| YES | | WWII | | 136-10-4755 | | |
| 18. CAUSE OF DEATH | | 19. INFORMANT | | | | |
| PART I. DEATH WAS CAUSED BY: | | MAY NORMA MCNALLY WIFE SAME AS 13 | | | | |
| IMMEDIATE CAUSE (a) | | Cardiac Arrest | | | | |
| 3349 | | DUE TO, OR AS A CONSEQUENCE OF | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | Cerebral Degeneration | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | |
| | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 81, to 19 83, that (I) (we) last saw the deceased alive on Dec 10 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
DEGREE | | | 22c. DATE SIGNED | |
| John J. Merendino, M.D. | | 11620 Kemp Mill Road Silver Spring, Md. | | | 12/12/83 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| BURIAL | | DEC. 16, 1983 | | GATE OF HEAVEN CEMETERY | | SILVER SPRING MONT. MD. |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| FRANCIS J. COLLINS | | DEC 15 1983 | | John J. Merendino | | |
| 500 UNIVERSITY BOULEVARD, W. SILVER SPRING, MD. | | | | | | |



UNITED STATES DEPARTMENT OF JUSTICE

A

Handwritten: Charles (Mort)
Richard (Mort)

X



Handwritten: [Signature]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME
FIRST MIDDLE LAST
ELSIE G. MC PHERSON | | | 2a. DATE OF DEATH MONTH DAY YEAR
12-14-83 | | | 2b. HOUR
8:20 P.
M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Feb. 19, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Potomac Valley Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired clerk | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John Gingell | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Ellen Darcey | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(NO OR UNKNOWN) No IF YES, GIVE WAR OR DATES) ---- | | 16b. SOCIAL SECURITY NO.
721-18-9747 | | 17. INFORMANT ADDRESS
J.B. McPherson same as 13c | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
3314 IMMEDIATE CAUSE (a) Respiratory and Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebrovascular accident
DUE TO, OR AS A CONSEQUENCE OF
(c) Hydrocephalus | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 months
6 months |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **----**

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Hydrocephalus | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
---- | | | |
| 21d. INJURY OCCURRED
WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
---- | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
6304 Democracy Blvd. Bethesda Md 20814 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 19 80 , to Dec 14 19 83 , that (I) (we) last saw the deceased alive on Dec 14 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
John W. Barrett | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12-14-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John W. Barrett | | 22e. ADDRESS
6304 Democracy Blvd. Bethesda Md 20814 | | | | | |

| | | | | | | | |
|---|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
TYPE Burial | | 23b. DATE
12/17/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Maryland | |
|---|--|------------------------------|--|--|--|--|--|

| | | | | | |
|---|--|---|--|---|--|
| 24. FUNERAL DIRECTOR
NAME
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Md. 20852 | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | |
|---|--|---|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for necropsy.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP 481

Items 18-22a 3/12/84 mtb F#589

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|---------|---|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| JUANITA G. McRAE | | | 12 26 1983 | | | 7:58P | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | | |
| Female | Black | August 19, 1947 | 36 YRS. | | | 12 26 1983 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| D. C. | | U.S.A. | | | | Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Takoma Park | | Washington Adventist Hospital | | | Secretary | | Hospital | |
| 13a. STATE | | | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| Maryland | | | | Montgomery | Takoma Park | 7667 Maple Avenue, Apt. 210 | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| Oscar Golson | | | | Katherine Mickens | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | |
| No | | | | 578-66-9486 | | Washington, D. C. 20010
Katherine Richardson, mother, 1851 Newton NW | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocarditis</u>
4290
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held in Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | | DATE SIGNED | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | DATE SIGNED | |
| Thomas D. Smith, M.D. | | | 111 Penn St. Balto., MD. | | | | 12/27/83 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | | Dec. 31, 83 | | Harmony Memorial Park | | Highland Park, Maryland | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| McGuire Funeral Service, Inc. 7400 Georgia Ave. NW Washington, DC | | | | | JAN 6 1984 | | John J. Carver | |

RECEIVED

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
PHYLLIS ANN MECAUGHEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 21 1983 | | 2b. HOUR
1:17 a
M | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPTEMBER 5 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
KANSAS | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
STOCK BROKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
VIRGINIA | | 13b. COUNTY
FAIRFAX | | 13c. CITY OR TOWN
ALEXANDRIA | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
OTTO ELLIS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EDNA Lyndley | | 13e. STREET ADDRESS
1002 DANTON LANE | | 99999 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
- N/A 429-59-9563 | | 17. INFORMANT
ADDRESS
ROBERT W. MECAUGHEY, 1002 DANTON LANE, | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
1749 IMMEDIATE CAUSE (a) ALEXANDRIA, VA 22308
ADENOCARCINOMA OF THE BREAST | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last. | | (b) |
| DUE TO, OR AS A CONSEQUENCE OF | | (c) |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 8, 1983 , to DECEMBER 21, 1983 , that (I) (we) lost
saw the deceased alive on DECEMBER 21, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Victor A. Aletich MD</i> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
21 Dec 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
VICTOR A. ALETICH, LCDR, MC, USNR | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | |

| | | | | | | | |
|--|--|-------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec 23 83 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Va. | |
| 24. FUNERAL DIRECTOR
NAME <i>Wayne F. Fitch</i> ADDRESS
Demaine Funeral Homes, Inc., Alex., Va. 22314 | | | | 25. REGISTRAR'S SIGNATURE
DEC 28 1983 | | | |

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

REPORT OF

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UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOSEPH LORAN MERCER | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 23, 1983 | | | 2b. HOUR
3:00A M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 5, 1983 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Institutes of Health Clinical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Music Director | | 12b. KIND OF BUSINESS OR INDUSTRY
Education | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
WV | | 13b. COUNTY
Ohio | | 13c. CITY OR TOWN
Wheeling | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
121 N. 11th St 26003 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph W. Mercer | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Matilda F. Schwartzwalder | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
NO OR UNKNOWN | | 16b. SOCIAL SECURITY NO.
(DATE OF BIRTH OR DATE)
N/A | | 17. INFORMANT
ADDRESS
Helen Mercer (wife) Same as #13 | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIAC ARYTHMIA

4140
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) CARDIAC FAILURE

DUE TO, OR AS A CONSEQUENCE OF

(c) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION
12/20/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Coronary Artery Disease | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 3, 1983 to December 23, 1983, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 23, 1983, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Dr David Underhill | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/23/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID UNDERHILL | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, MD 20205 | | | |

| | | | | | | | |
|--|--|-----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
12-27-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cemetery | | 23d. LOCATION
Wheeling, West, Virginia | |
| 24. FUNERAL DIRECTOR
NAME
IVES - PRARONE Etc | | | | 24b. ADDRESS
Arlington, Va. 22201 | | 25a. DATE OF REGISTRATION
DEC 29 1983 | |
| 25b. REGISTRAR'S SIGNATURE
John J. Carver | | | | 25c. REGISTRAR'S SIGNATURE | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|------------------------|--|--|---|-------------------------------|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JOSEPH ANTHONY MEROS | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH <input checked="" type="checkbox"/> 12 DAY 9 YEAR 1983 | |
| 3. SEX
Male | 4. RACE
Cauc | 5. DATE OF BIRTH
MONTH 8 DAY 6 YEAR 64 | 6. AGE (IN YEARS)
LAST BIRTHDAY 19 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | IF UNDER 24 HRS.
HOURS MIN | 7c. DATE PRONOUNCED DEAD
MONTH 12 DAY 10 YEAR 1983 | | 2d. HOUR
PM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PEPCO POWER LINE (St James) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
STUDENT | | 12b. KIND OF BUSINESS OR INDUSTRY
School | | | |
| 13a. STATE
MD | | | | | | | | | | 13b. CITY OR TOWN
MONTGOMERY | |
| 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13d. STREET ADDRESS
12211 DEVILWOOD DR | |
| 14. FATHER'S NAME
FIRST Edward MIDDLE J. LAST Meros | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Alice MIDDLE Niedzwiecki LAST Niedzwiecki | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
213-90-0818 | | | 17. INFORMANT ADDRESS
Edward J. Meros same as 13c | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) GUNSHOT WOUND
9551
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION
- | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
- | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
PM P.M. 12 9 1983 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
SHOTGUN IN CHEST | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
WOODS | | | | 21f. LOCATION
STREET PEPCO Power line St James CITY OR TOWN Rockville COUNTY Montgomery STATE MD | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
Francis C Mayle | | | | TIME (SPECIFY)
5:15 M.D. | | | | MEDICAL EXAMINER
20814 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Francis C Mayle | | | | ADDRESS
5200 Wisconsin Ave BETHESDA MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
12/14/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | | | 23d. LOCATION
CITY OR TOWN Silver Spring COUNTY Maryland STATE Md | |
| 24. FUNERAL DIRECTOR
NAME Tyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike Rockville, Md. 20852 | | | | | | 25. DATE REC'D. BY REGISTRAR
DEC 16 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Canine | | | |

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#1, & 14, 15, Film G587 1/10/84 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|------------------|---|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Lillian B. Mortens | | | 2a. DATE KNOWN OF DEATH
MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 1983 | | | 2b. HOUR <input checked="" type="checkbox"/> MIN. <input checked="" type="checkbox"/> 12 P. M. | | |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH
MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 1915 | 6. AGE (IN YEARS)
LAST BIRTHDAY <input checked="" type="checkbox"/> MONTHS <input checked="" type="checkbox"/> DAYS <input checked="" type="checkbox"/> HOURS <input checked="" type="checkbox"/> MIN. <input checked="" type="checkbox"/> 68 YRS. | IF UNDER 1 YR.
MONTHS <input checked="" type="checkbox"/> DAYS <input checked="" type="checkbox"/> HOURS <input checked="" type="checkbox"/> MIN. <input checked="" type="checkbox"/> | IF UNDER 24 HRS.
MONTHS <input checked="" type="checkbox"/> DAYS <input checked="" type="checkbox"/> HOURS <input checked="" type="checkbox"/> MIN. <input checked="" type="checkbox"/> | 7c. DATE PRONOUNCED DEAD
MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 1983 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH
S. L. Spr. | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
H. L. Cross Hosp | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
OPERATOR | | |
| 13a. STATE
MD | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
13712 Sherwood Forest Dr. | | |
| 14. FATHER'S NAME
FIRST WALTER MIDDLE R. LAST BREY | | | 15. MOTHER'S MAIDEN NAME
FIRST LILLIAN MIDDLE F. LAST RING | | | 16. SOCIAL SECURITY NO.
060-03-7118 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO.
060-03-7118 | | | 17. INFORMANT
JOHN MORTENS (HUSBAND) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Dis
4291
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
None | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
John S. Rogers | | | TITLE (SPECIFY)
Dep. | | | MEDICAL EXAMINER
DEC. 13/1983 | | |
| EXAMINER'S NAME
(TYPE OR PRINT) JOHN S. ROGERS | | | ADDRESS
SILVER SPRING, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) CREMATION | | | 23b. DATE
DEC/15/83 | | | 23c. NAME OF CEMETERY OR CREMATORY
CHAMBERS CREMATORY | | |
| 23d. LOCATION
CITY OR TOWN
RIVERDALE, PG. RD. 2, MARYLAND | | | COUNTY
DEK | | | | | |
| 24. FUNERAL DIRECTOR
NAME
CHAMBERS FUNERAL HOME SILVER SPRING, MD. | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



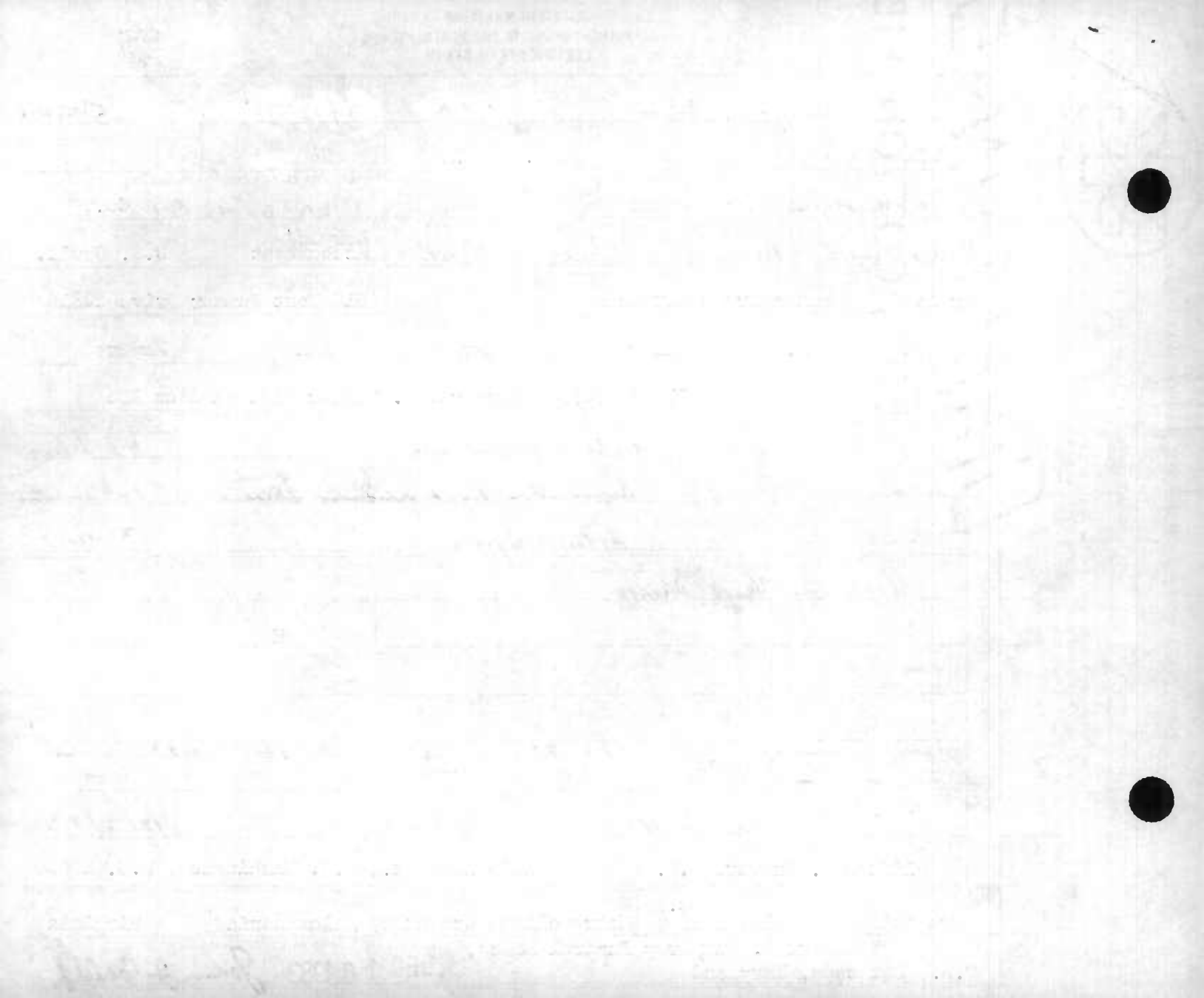
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Clarence Wagner Miller | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 12, 1983 | | | 2b. HOUR
5:55 PM | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
Sept. 25, 1889 | | 6. AGE (IN YEARS, LAST BIRTHDAY)
94 YRS | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CI. OR COUNTY OF DEATH
MONTGOMERY Co., MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Rockville Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OR MOST OF WORKING LIFE)
Lawyer Accountant | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE Maryland 13c. COUNTY Montgomery 13d. CITY OR TOWN Bethesda 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13f. STREET ADDRESS
4816 Fort Sumner Drive 20816 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Aaron J. Miller | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Ann Meyers | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
WW I 578 66 6035 | | 17. INFORMANT ADDRESS
Margaret B. Miller Wife same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4370
IMMEDIATE CAUSE (a) Branchopneumonia
DUE TO, OR AS A CONSEQUENCE OF
(b) Degenerative Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerosis | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 hours
10 months
3 years | |
| | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Coronary Heart Disease | |
| | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb. 23, 1983 to Dec. 12, 1983 , that (I) (we) last saw the deceased alive on Nov. 26, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
C. R. Gruver M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/12/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Clifton R. Gruver, M.D. | | | | 22e. ADDRESS
#202 1145 19th St., N.W. Washington, D.C. 20036 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Dec. 13, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Alexandria Virginia | | | |
| 24. FUNERAL DIRECTOR NAME
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connelley | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the records after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

#5,6, FilmG586 12/16/83 kam
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|--|--|---|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ELEANORA T. MILLER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 7, 1983 | | 2b. HOUR
2:15 A.M. | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 26, 1921 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto. Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker Ret. At Home | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-01-5186 | | 17. INFORMANT
ADDRESS
Mr. John E. Miller, 3102 Kingtree Street
Wheaton, Md. 20902 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4960 IMMEDIATE CAUSE (a) Respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF Stroke TO P.D.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Stroke
(c) Stroke
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
acute
ypc | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Anemia + Bleeding - Thyroid disease | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 11-4-83 , to 12-7-83 , that (1) last saw the deceased alive on 12-6-83 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (1) we did did not view the body after death. | | | | | | |
| 22b. SIGNATURE
John S. Saia | | DEGREE
M.D. | | 22c. DATE SIGNED
Dec. 7, 1983 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN S. SAIA, M.D. | | 22e. ADDRESS
809 Viers Mill Road, Rockville, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 9, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Mem. Pk. | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Mont. Cty., Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
W.W. CHAMBERS CO., 8655 Ga. Ave., S. S. Md. | | | | |
| 25a. DATE REC'D. BY REGISTRAR
DEC 9 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | | | | |

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#5,6, FILING 586 12/20/83 kam
FOR
1- STATE #13d, per F.H.
REGISTRAR 1/10/84 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 3 7 5 9
REG. NO.

| | | | | | | | | | |
|--|---------------------|---|--|---|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Raymond H. Miller | | | | 2b. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12-9-83 | | | | 2d. HOUR 12:45 P.M. | |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR 12-23-23 | 6. AGE (IN YEARS)
LAST BIRTH MONTHS DAYS 59 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 12-9-83 | | 7d. HOUR 12:45 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Indiana | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(SUCH FACILITY, GIVE STREET ADDRESS)
Bethesda Md. Suburban Hosp. Comprehensive Aux. Tech. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
20912 | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
TAKOMA PARK | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
8024 GLENSIDE DRIVE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST William H. Miller Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Markwell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) Yes - WWII | | | | 16b. SOCIAL SECURITY NO.
579-20-3416 | | 17. INFORMANT
ADDRESS Lush L. Miller (Wife) 8024 Gleaside Dr. Tak. Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) HYPERTENSIVE CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ACUTE
YRS | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR 12 P.M. 12 9 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
COLLAPSED AT JOBS | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
WORK | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
8101 RUGBY AVE BETHESDA MONT MD | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE Francis C. Myle | | | TITLE (SPECIFY)
M.D. DEPT MEDICAL EXAMINER | | | DATE SIGNED 12/9/83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Francis C. Myle | | | ADDRESS 8200 Wisconsin Ave Bethesda MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial. | | | 23b. DATE
12/13/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Maryland Veterans | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cheltenham, P. G., Md. | | |
| 24. FUNERAL DIRECTOR
NAME Takoma Funeral Home | | | 25a. DATE RECD. BY REGISTRAR
14 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Gansh | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PREPARED FOR BURIAL, CREMATION, OR REMOVAL.

W.C.A. 10/10/83
10/10/83
10/10/83

10/10/83
10/10/83
10/10/83

10/10/83
10/10/83
10/10/83

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove coroner's papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) ELLIOTT WATERS MONTEROLL | | | | | 2a. DATE OF DEATH
MONTH 12 DAY 3 YEAR 83 2b. HOUR 3:55P_M | | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH 5 DAY 4 YEAR 16 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
67 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN WHICH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Prpf. Physicist | | 12b. KIND OF BUSINESS OR INDUSTRY
U. of Md. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Chevy Chase | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
4 Laurel Pkwy 20815 | | |
| 14. FATHER'S NAME
FIRST Adolph MIDDLE Baer LAST Montroll | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Esther MIDDLE LAST Israel | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, DATE UNKNOWN) NO (IF YES, GIVE WAR OR DATES) ----- | | 16b. SOCIAL SECURITY NO.
126-18-9280 | | 17. INFORMANT
ADDRESS
Mrs. Shirley Montroll (wife) same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Tampanade
2000 DUE TO, OR AS A CONSEQUENCE OF
(b) Diffuse Histiocytic Lymphoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Minutes
8 months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 3, 1983 , to December 3, 1983 , that (I) (we) last saw the deceased alive on November 23, 1983 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Eric J. Seyfer MD | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/3/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ERIC J. SEYFER | | | | 22e. ADDRESS
National Institutes of Health, 9000 Rockville Pike, Bethesda, Maryland 20205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
12-6-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Lebanon Cemetery | | 23d. LOCATION
CITY OR TOWN Hyattsville, Md. COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike ADDRESS Rockville, Md. | | | | 25a. DATE REQUIRED FOR BURIAL (PART 2) DEC 8 1983 John J. Connelley | | | | | |

BP



ERIC T. REIFLER
Gen. / [Signature]

~~X~~

10/3/10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

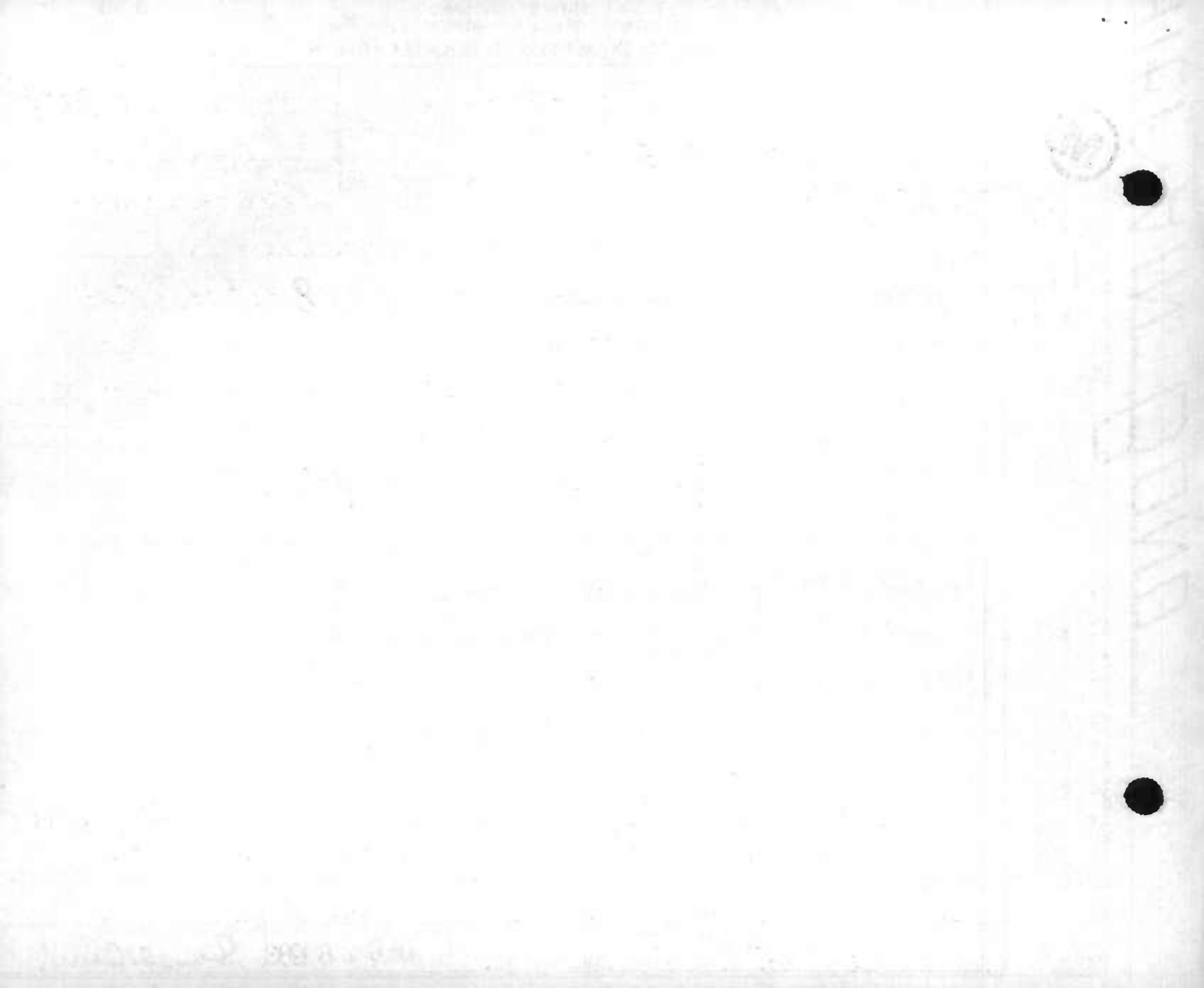
BP _____

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|---------------------|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Francis (Frank) Moore</i> | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
<i>Dec 26 1983</i> | | | |
| 3. SEX
<i>M</i> | 4. RACE
<i>W</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>Aug 20 1928</i> | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
<i>55</i> | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
<i>Dec 26 1983</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Washington, D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>138 Ritchie Ave</i> | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Carpenter</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
<i>MD</i> | | 13b. COUNTY
<i>Mont</i> | 13c. CITY OR TOWN
<i>Silver Spring</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
<i>138 Ritchie Ave</i> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Robert S. Moore, Sr.</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Bertha Margaret Reynolds</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>214-03-9517</i> | | 17. INFORMANT
ADDRESS
<i>Josephine M. Moore Wife Same as 13</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Myocardial Inf</i>
4960
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) <i>Chronic Obstructive Pul. Dis</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.
<i>Alcoholism</i> | | | | | | | |
| 19a. DATE OF OPERATION
<i>None</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
<i>John S. Rogers</i> | | TITLE (SPECIFY)
<i>Dep.</i> | | MEDICAL EXAMINER | | DATE SIGNED
<i>Dec 26 1983</i> | |
| EXAMINER'S NAME
(TYPE OR PRINT)
<i>John S. Rogers, M.D.</i> | | ADDRESS
<i>1919 Seminary Rd. Silver Spring, Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>Dec. 28, 1983</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>George Washington</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Adelphi Pr. Geo. Md.</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>Francis J. Gollins</i>
<i>500 University Blvd., W. Silver Spring, Md.</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 28 1983</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Canine</i> | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) Eugene Patrick Moran | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-12-83 | | 2b. HOUR
7:20 AM | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 6, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Principal | | 12b. KIND OF BUSINESS OR INDUSTRY
Education | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Patrick L. Moran | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Kathryn Hunt | | 13e. STREET ADDRESS
537 Brent Road (20850) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT
ADDRESS
Rosemary C. Moran, same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) Cardio-respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Myocardial Infarction x 2
DUE TO, OR AS A CONSEQUENCE OF
(c) Coronary Thrombosis & Coronary art.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 3 mos 8 1 mon 4 mon
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
Perkussion Multiple C.V.A.s & Rheumatoid arthritis & Osteoarthritis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/1/83 to 12/12/83 , that (I) (we) last saw the deceased alive on 12/1/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Stephen N. Jones | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/12/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stephen N. Jones, M.D. | | 22e. ADDRESS
809 Veirs Mill Road
Rockville, Maryland 20850 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 15, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100

12-12-25

Expend 1-10-0

100

Handwritten

Handwritten



Handwritten text, possibly a date or reference number.

Handwritten text, possibly a date or reference number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>John A. Moreland</i> | | | | 2b. DATE OF DEATH MONTH DAY YEAR 26. HOUR
<i>December 24, 1983 9:15 P.M.</i> | | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>July 12 1916</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>67</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Holy Cross Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Engineer</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Walter Reed Hospital</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
<i>Maryland Montgomery Silver Spring</i> | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Charles A. Moreland</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Katherine Elsa</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>No</i> | | | | 16b. SOCIAL SECURITY NO.
<i>229-07-0038</i> | | | |
| 17. INFORMANT
<i>Anna Moreland</i> | | | | ADDRESS
<i>Wife Same as 13</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiogenic Shock</i>
<i>4280</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Congestive Heart Failure</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<i>Acute Tubular Necrosis Severe Chronic Obstructive Lung Disease</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10-27, 1983</i> , to <i>12-24, 1983</i> , that (I) (we) last saw the deceased alive on <i>10-24, 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Steven A. Burger</i> | | | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>12-25-83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Steven A. Burger</i> | | | | 22e. ADDRESS
<i>2101 Medical Park Dr. Silver Spring, Md</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>12/29/83</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Gate of Heaven</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Silver Spring Mont. Md.</i> | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Francis J. Collins
500 University Blvd., W. Silver Spring, Md.</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 28 1983</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Canine</i> | |

BP



CHIEF
FOX COLLIER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

Item 23c, Film#G588
FOR 2/7/84jlb
1- STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Darrell Lee Morgan | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-11-83 | | | 2b. HOUR
4:50 AM | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
1-25-41 | | 6. AGE (IN YEARS LAST BIRTHDAY)
42 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
W.Va. | | 7c. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Office Manager | | 12b. CREATIVE OR INDUSTRY
Plantings | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Md. | | | 13c. CITY OR TOWN
PG | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2114 Rolander Street | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Floyd Morgan | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillian Morgan | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
US Navy | | 17. INFORMANT
Rt. 02 Ronceverte, W.Va. | | 17b. Lillian Morgan (Mother) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Severe hemorrhagic Pancreatitis
5770
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 wks | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Pulmonary & Renal failure - Sepsis | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-10-83 to 12-10-83 , that (I) (we) last saw the deceased alive on 12-10-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death) | | | | | | | | | |
| 22b. SIGNATURE
Robert A. Smith | | | 22c. DATE SIGNED
12-11-83 | | | 22d. ADDRESS
831 University Blvd SS. Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/14/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenbrier Regular Baptist Church Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Ronceverte Greenbrier W.Va. | | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi | | | 25. DATE REC'D. BY REGISTRAR
DEC 13 1983 | | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|
| 1. FOR
STATE
REGISTRAR | | | 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| | | | FIRST MIDDLE LAST
PATRICIA TABLER MOUNT | | | December 15, 1983 | | | 9:10A M | | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 22, 1933 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
50 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Illinois | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NIH, The Clinical Center | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | |
| 13a. STATE
West Virginia | | | 13b. COUNTY
Berkeley | | | 13c. CITY OR TOWN
Inwood | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lee Tabler | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marie Griffin | | | 13e. STREET ADDRESS
Rt. 2, Box 257 | | | 13f. CITY OR TOWN
25428 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
332-28-3938 | | | 17. INFORMANT
Mr. William Mount (husband) | | | 17. ADDRESS
Same | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

5728 IMMEDIATE CAUSE (a) **Upper gastrointestinal hemorrhage**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Bilateral pneumonia**DUE TO, OR AS A CONSEQUENCE OF **Liver failure secondary to**(c) **metastatic breast cancer**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOVEMBER 15 , 19 83 , to December 15 , 19 83 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on December 15 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (we) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Eugenia Legan | | | | DEGREE
MD | | 22c. DATE SIGNED
12/15/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EUGENIA LEGAN | | | | 22e. ADDRESS
National Institutes of Health, 9000 Rockville Pike, Bethesda, Maryland 20205 | | | |

| | | | | | | | |
|--|--|----------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
Dec 15, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
MARTINSBURG | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Berkeley W.Va | |
| 24. FUNERAL DIRECTOR
NAME
Brown Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1983 | | | |
| 25b. REGISTRAR'S SIGNATURE
John J. Canick | | | | | | | |

10

Upper gastrointestinal bleeding

Bilateral pneumonia

Liver failure secondary to
metastatic breast cancer

1/11/78

BC% 80-90



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Papers to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the manner in which death occurred should be marked on this certificate.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

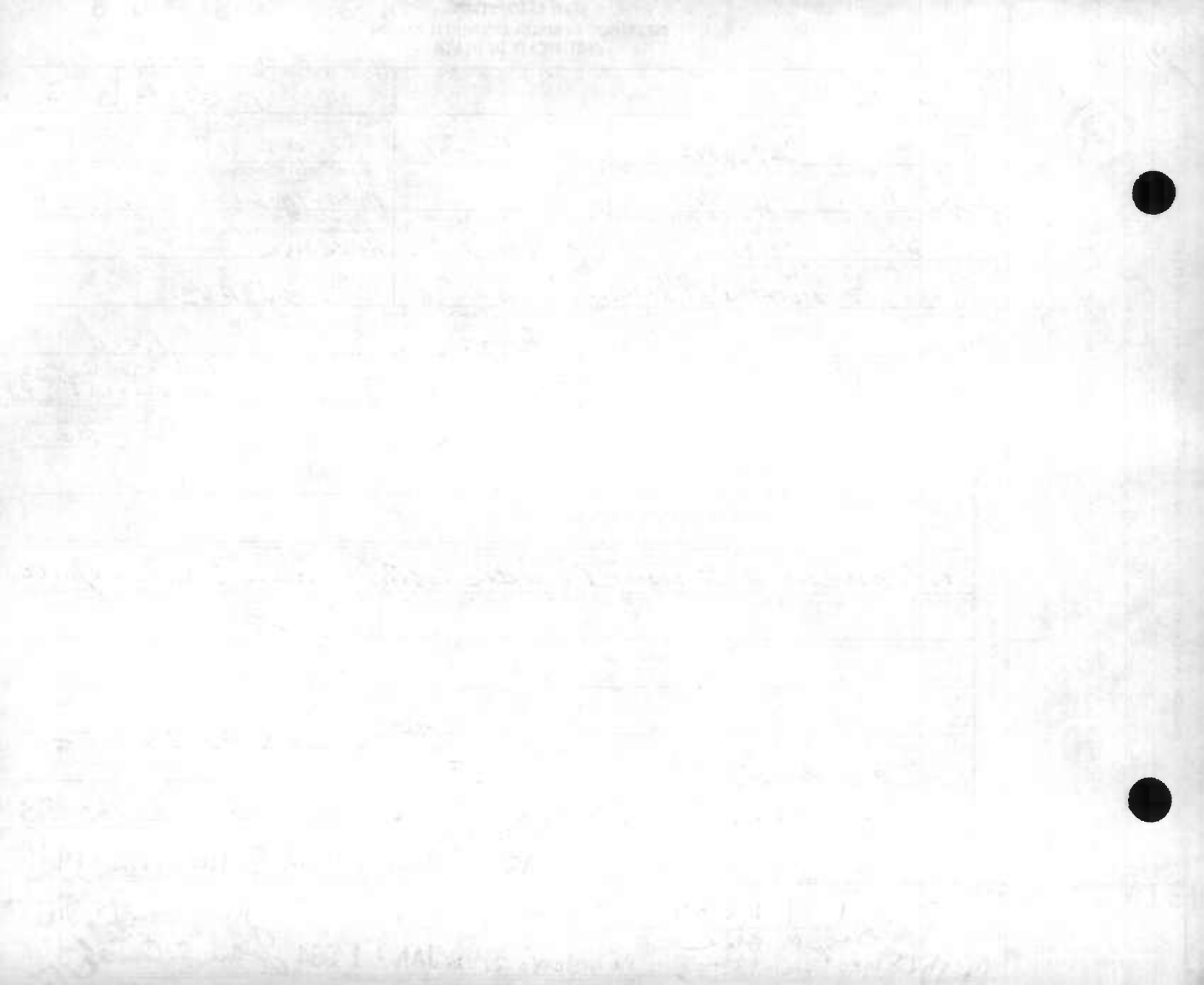
| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(Type in full)
<i>Elizabeth Mountjoy</i> | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>12/30/83</i> | | | | 2b. HOUR
<i>3 (A.M.)</i> | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>12 27 91</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>92</i> YRS. | | # UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Wash. D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery Co.</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Sp.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Carriage Hill, Silver Sp. Md.</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
<i>Md.</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Silver Spring</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>9101 Ind Ave.</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Charles Collins</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Fannie Reid</i> | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>NO</i> | | 16a. SOCIAL SECURITY NO.
<i>579-60-1097</i> | | 17. INFORMANT
ADDRESS
<i>Fall Church, Va. 22043
2420 Lexington Rd.</i> | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>acute bronchitis</i>
<i>4660</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 wks</i> | |
|---|--|--|--|

| | | | |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>advanced arteriosclerosis with organic brain syndrome</i> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

| | | | |
|---|--|--|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12-23-83</i> to <i>12-30-83</i> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <i>12-23-83</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, so state.) | | | |
| 22b. SIGNATURE
<i>George Sengstack</i> | | 22c. DATE SIGNED
<i>12-30-83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>George Sengstack</i> | | 22e. ADDRESS
<i>9241 Columbia Blvd. Silver Spring Md.</i> | |

| | | | | | | | |
|--|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>1-2-84</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>St. Johns Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>King George Va.</i> | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>John M. Blue Nash & Slaw Funeral Home Ninde Va. 22526</i> | | | | 25. DATE REC'D. BY REGISTRAR
REGISTRAR'S SIGNATURE
<i>JAN 1 1984 John J. Cunniff</i> | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|--|--|--|--|------------------------------------|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST
Edward A Moyle | | | MONTH DAY YEAR
Dec 2, 1983 | | | 3555 PM | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | |
| Male | | | Caucasian | | | MONTH DAY YEAR
July 10 1929 | | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| Washington, D.C. | | | U.S.A. | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| Silver Spring | | | Holy Cross Hospital | | | Ass't. Gen. Agent Insurance | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | |
| Maryland | | | Montgomery | | | Silver Spring | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| FIRST MIDDLE LAST
Edward D. Moyle | | | FIRST MIDDLE LAST
Elizabeth Hausch | | | 13e. STREET ADDRESS / ZIP CODE
1006 N. Belgrade Road 20902 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | | 17. INFORMANT ADDRESS | | |
| Yes | | | Korea | | | Vivan C. Moyle Wife Same as 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cardiac arrest | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ovarian carcinoma secondary to | | | | | | | | |
| (c) Cancer of the colon | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 2 , 19 83 , to Dec 2 , 19 83 , that (I) (we) last saw the deceased alive on Dec 2 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
John Merendino | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John Merendino | | | 22e. ADDRESS
11620 Kempmiller Rd Silver Spring | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Burial | | | Dec. 6, 1983 | | Ft. Lincoln Cemetery | | Brentwood Pr. Geo. Maryland | |
| 24. FUNERAL DIRECTOR
NAME | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Francis J. Collins
500 University Blvd., W. Silver Spring, Md. | | | DEC 13 1983 | | | John J. Connel | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Dec 21 1932

1932

1932



THE UNIVERSITY OF CHICAGO
LIBRARY
1932

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1932

1932

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|-------------------------|--|---|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mary J. Murray | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
12/25 1983 | | | | 2b. HOUR
M
5:48 | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 5, 1892 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
91 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS.
HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12/25 1983 | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerical | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S.A. Gov't | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Prince Georges | | 13c. CITY OR TOWN
Hyattsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward Barrett | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary E. Dunn | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO.
126-07-2243 | | 17. INFORMANT
ADDRESS
Daughter Mary Jane Murray - Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
4140 IMMEDIATE CAUSE (a) Arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) generalized arteriosclerosis and chronic obstructive pulmonary disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Fracture of right hip | | | | | | | | | |
| 19a. DATE OF OPERATION
12/6/83 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
Fracture of right hip | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 11/22 1983 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Fell at home | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
15th Ave., Hyattsville, Prince Georges, Md. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John S. Rogers</i> | | | TITLE (SPECIFY)
Deputy | | | MEDICAL EXAMINER
1919 Seminary Road | | | DATE SIGNED
12/27/83 |
| EXAMINER'S NAME
(TYPE OR PRINT)
John S. Rogers, M.D. | | | ADDRESS
Silver Spring, Montgomery, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
Dec. 27 '83 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia | |
| 24. FUNERAL DIRECTOR
<i>James E. DeVol</i>
DeVol Funeral Home
ADDRESS
Washington, D.C. | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Ganiel</i> | | |

JAN 2 1964

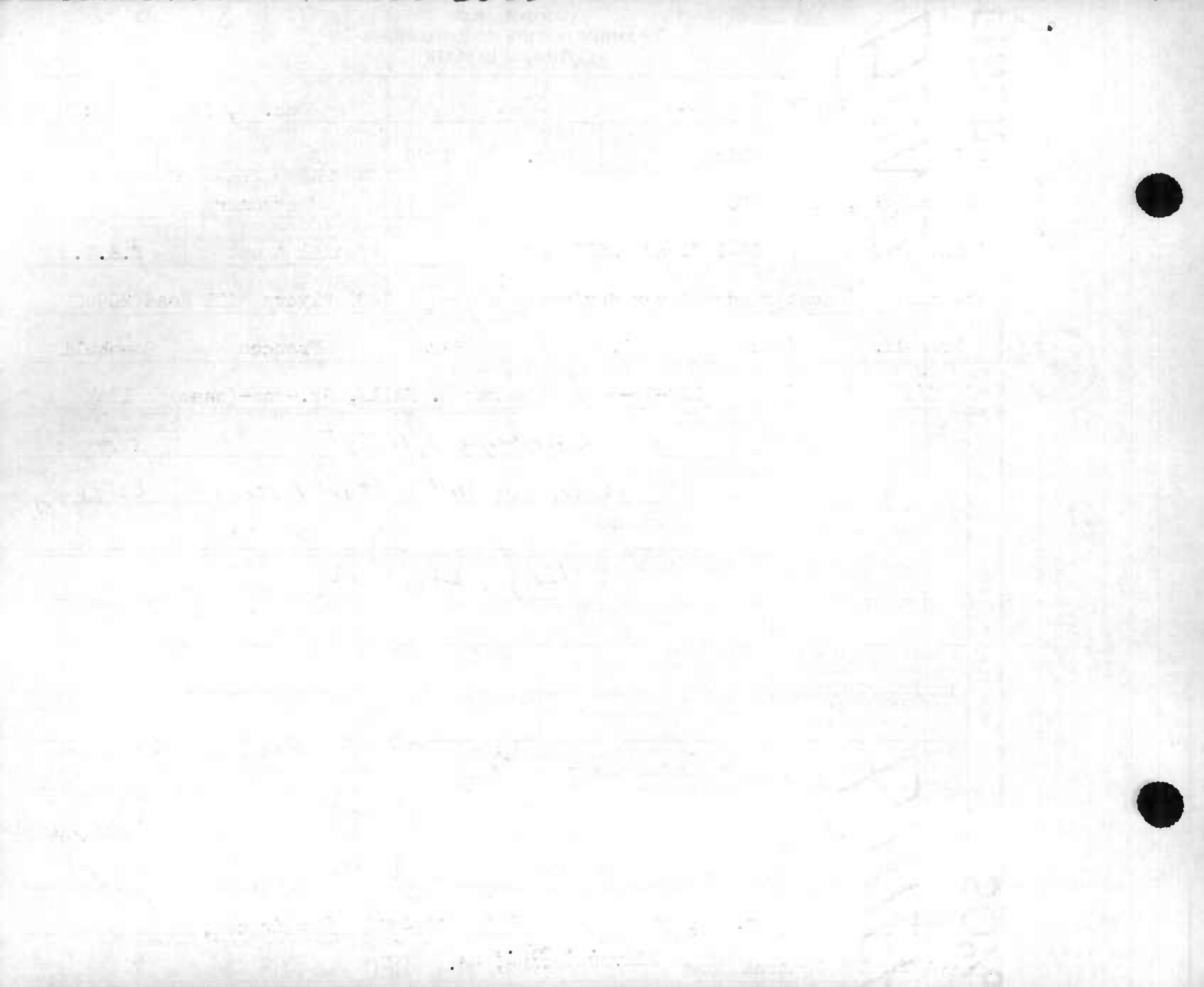
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 above any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
ROSSER L. NALLS | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 7, 1983 | | | 2b. HOUR
3:PM M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 30 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, DC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2801 Pliers Mill Road | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Special Agent | | 12b. KIND OF BUSINESS OR INDUSTRY
F.B.I. | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. STREET ADDRESS / ZIP CODE
2801 Pliers Mill Road 20902 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Franklin Pierce Nalls | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Frances Campbell | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT ADDRESS
Rosser L. Nalls, Jr.-son-(same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4140 IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Atherosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Hyperextension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 min
20 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) this hospital attended the deceased from Jan 19 74 to Dec 19 83 , that (we) last saw the deceased alive on 6 Dec 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22a. SIGNATURE
[Signature] | | | | DEGREE
MD | | | | 22c. DATE SIGNED
7 Dec 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael Leibovitch, MD | | | | 22e. ADDRESS
1120 N. H. Ave., Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 10, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, DC | | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi Funeral Home | | | | 11800 N.H. Ave.,
Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1983 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
GERTRUDE E NEUMEYER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 18 1983 | | 2b. HOUR
5:30 AM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 11 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash., D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN BALTIMORE CITY OR COUNTY ADDRESS)
5611 Ogden Road | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Asst. Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
Peoples Life Ins. Co. |
| 13a. STATE
Del. 19971 | | 13b. COUNTY
Sussex | 13c. CITY OR TOWN
Rehoboth | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
38 Rolling Road 99999 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Conlon | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Josephine O'Leary | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
577-10-0501 | | 17. INFORMANT
ADDRESS
Maryland. 20816
Mary V.O'Donnell. 5611 Ogden Rd., Bethesda. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma liver
DUE TO, OR AS A CONSEQUENCE OF (b) Elderly Carcinoma ascending Colon
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
21 months. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) the hospital attended the deceased from 3/26 , 19 82 , to 12/18 , 19 83 , that (I) lost saw the deceased alive on 12/17 , 19 83 , and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (If deceased did not visit the hospital after death) | | | | | |
| 22b. SIGNATURE
J. Blaine Fitzgerald DEGREE | | | | 22c. DATE SIGNED
12/18/83. | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. Blaine Fitzgerald | | | | 22e. ADDRESS
8218 Wisconsin Ave., Bethesda, Md. 20814 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/20/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Congressional Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington D.C. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C. | | | |
| 25. DATE REC'D. BY REGISTRAR
DEC 22 1983 | | | | 25. REGISTRAR'S SIGNATURE
John J. Conner | |

12/20/1983 Contractual Cemetery Washington D.C.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Helen Nickolson NORRED</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>12 20 83</i> | | | 2b. HOUR
<i>830 PM</i> | | | |
| 3 SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>9-4-1908</i> | | 6. AGE
(IN YEARS LAST BIRTHDAY)
<i>75</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<i>Wash. D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery County MD.</i> | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda Md.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Suburban Hospital 8600 Old George Town Rd. Bethesda Md.</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Proprietor Dance</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Studio Dance</i> | |
| 13a. STATE
<i>Md.</i> | | 13b. COUNTY
<i>AA Co.</i> | | 13c. CITY OR TOWN
<i>Edgewater</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
<i>3730 Bay Dr. 21037</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Isaac D. Porter</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Chrissie S. Thurston</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>No</i> | | | | 16b. SOCIAL SECURITY NO.
<i>219-32-4088</i> | | 17. INFORMANT
ADDRESS
<i>Vivian Gills Same as #13</i> | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

4100 IMMEDIATE CAUSE (a) *Intractable Congestive Heart Failure* APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH *1 week*
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) *Acute Anterior Myocardial Infarct* *1 week*
DUE TO, OR AS A CONSEQUENCE OF (c) *Hypertensive Cardiovascular Disease* *Several years*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

Type II Hyperlipoproteinemia Diabetes Mellitus Insulin Dependent

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☒ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK
21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (the hospital) attended the deceased from *Nov 56* to *20 Dec 83*, that (I) *lost* saw the deceased alive on *20 Dec 1983*, and that in (my) *opinion* death occurred on the date and hour and from the causes stated above, (I) *did not* (did not) view the body after death.

22b. SIGNATURE
Michael M. Healy MD DEGREE
22c. DATE SIGNED
12/21/83

22d. PHYSICIAN'S NAME (TYPE)
Michel M. HEALY MD 22e. ADDRESS
5652 Shields Dr. Bethesda MD 20814

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) *Burial* 23b. DATE
12-22-83 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Baltimore Md.

24. FUNERAL DIRECTOR
NAME ADDRESS
Hardesty Funeral Home Annapolis, Md. 25a. DATE REC'D. BY REGISTRAR
DEC 22 1983 25b. REGISTRAR'S SIGNATURE
John J. Carver

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled without delay with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

THE UNIVERSITY OF CHICAGO
LIBRARY



RECEIVED

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|------------------------------------|---|------------------------------|--|--------------------------------|--|---|---|------|
| DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF
DEATH | | MONTH | DAY | YEAR | 2b. HOUR | MIN. |
| SEX | | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | 6. AGE (IN YEARS
LAST BIRTHDAY) | IF UNDER 1 YR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE
PRONOUNCED
DEAD | | MONTH DAY YEAR | 2d. HOUR MIN. | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | 10. KIND OF BUSINESS
OR INDUSTRY | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | 12c. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | 20906 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
4029
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:
(b) <u>Hypertensive Ht. Dis.</u>
(c) _____
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
<u>None</u> | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | TITLE (SPECIFY)
DATE SIGNED | | 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | |
| ACTUAL SIGNATURE
<u>John S. Rogers</u> M.D. | | EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR'S NAME | | 24b. DATE REC'D. BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | | 24d. DATE REC'D. BY REGISTRAR | | 24e. REGISTRAR'S SIGNATURE | | 24f. DATE REC'D. BY REGISTRAR | |
| 24a. FUNERAL HOME | | 24b. DATE REC'D. BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | | 24d. DATE REC'D. BY REGISTRAR | | 24e. REGISTRAR'S SIGNATURE | | 24f. DATE REC'D. BY REGISTRAR | |

1331 Rockville Pike Rockville, Md. 20852

DEC 19 1983

John S. Rogers



DHMM: 16 30M 2/80
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Mary Catherine O'Connell | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
Dec. 1, 1983 | | | | 2b. HOUR MIN.
12 P.M. | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 23 1885 | | 6. AGE (IN YEARS LAST BIRTHDAY)
98 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Dakota | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5900 Searl Terrace | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
Private Schools | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
5900 Searl Terrace (20816) | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William B. O'Connell | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ellen --- Crowley | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
Unavailable | | 17. INFORMANT
Nephew
John W. O'Connell | | | ADDRESS
Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>central vascular accident</u>
<u>4360</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>central atherosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>48 hrs.</u>
<u>years.</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 15</u> , 19 <u>81</u> , to <u>PRESENT</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Nov 30</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Jerome T. O'Connell</u> M.D. | | | | | 22c. DATE SIGNED
<u>Dec 1, 1983</u> | | | | | 22d. ADDRESS
<u>10401 OLD GORGETOWN Rd. Bethesda</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
<u>Dec. 3, 1983</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Olivet Cemetery</u> | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Washington D.C.</u> | | | | | |
| 24. FUNERAL DIRECTOR
NAME <u>Robert A. DeSol</u> ADDRESS <u>Washington D.C.</u> | | | | | DATE REC'D. BY REGISTRAR
<u>DEC 5 1983</u> | | REGISTRAR'S SIGNATURE
<u>John J. Smith</u> | | | | | | |

BP



UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D.C. 20250
JAN 10 1963
OFFICE OF THE CHIEF OF BUREAU

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

33174

REG. NO.

| | | | | | | | |
|--|------------------|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) GARLAND CECIL OFFENBACKER | | | | 2a. DATE KNOWN OF DEATH
MATED <input checked="" type="checkbox"/> Dec 3 1983 | | | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH
MONTH April DAY 20 YEAR 1919 | 6. AGE (IN YEARS)
LAST BIRTHDAY 64 YRS. | 7. IF UNDER 1 YR.
MONTHS 0 DAYS 0 | 7. IF UNDER 24 HRS.
HOURS 0 MIN 0 | 2c. DATE PRONOUNCED DEAD
Dec 3 1983 | |
| 1a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 11. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp | | | | 17a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Project Manager | |
| 12b. KIND OF BUSINESS OR INDUSTRY Ed.
Mont. Cty. | | | | | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY Monts 13c. CITY OR TOWN Silver Spring | | | | | | | |
| 14. FATHER'S NAME
FIRST John MIDDLE L. LAST Offenbacher | | | | 15. MOTHER'S MAIDEN NAME
FIRST Minnie MIDDLE Thomas LAST Thomas | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
223-14-9606 | | 17. INFORMANT
Vera S. Offenbacher ADDRESS Wife Same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Dis
4291 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:
(b) Chronic Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF
(c) 174 yr. | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
None | | | | | | | |
| 19a. DATE OF OPERATION
None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | |
| 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers M.D. Dep | | | | TITLE (SPECIFY) MEDICAL EXAMINER | | | |
| EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS | | | | ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 6, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION
CITY OR TOWN Silver Spring COUNTY Mont. STATE Md. | |
| 24. FUNERAL DIRECTOR NAME
Francis J. Coblins | | | | 25a. DATE REC'D BY REGISTRAR
DEC 13 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carish | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | | | |

RECEIVED
FEB 1 1964
U.S. AIR FORCE

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report with several paragraphs.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) BENNIE OLEWACK | | | | | 2a. DATE OF DEATH DECEMBER 15, 1983 | | | | |
| 3 SEX MALE | | | | | 4 RACE WHITE | | | | |
| 5. DATE OF BIRTH 05 D3 09 | | | | | 6 AGE (IN YEARS LAST BIRTHDAY) 74 | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) FRANCE | | | | | 7b CITIZEN OF WHAT COUNTRY? U. S. A. | | | | |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY | | | | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL | | | | |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF-EMPLOYED | | | | | 12b KIND OF BUSINESS OR INDUSTRY REAL ESTATE | | | | |
| 13a STATE MD | | | | | 13b COUNTY MONT. | | | | |
| 13c CITY OR TOWN CHEVY CHASE | | | | | 13d INSIDE CITY LIMITS? YES | | | | |
| 13e STREET ADDRESS 8404 GRUBB RD. | | | | | 14 FATHER'S NAME FIRST HARRY MIDDLE VICTOR LAST OLEWACK | | | | |
| 15 MOTHER'S MAIDEN NAME FIRST ROSE MIDDLE SWITZER LAST SWITZER | | | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | |
| 16b SOCIAL SECURITY NO. 579-40-4620 | | | | | 17 INFORMANT 5200 SARATOGA AVENUE | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4413 DUE TO, OR AS A CONSEQUENCE OF (b) RUPTURED ABDOMINAL AORTIC ANEURYSM DUE TO, OR AS A CONSEQUENCE OF (c) 4413 | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hr | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION 12/15/83 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED RUPTURED ABDOMINAL AORTIC ANEURYSM | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/15 , 19 83 , to 12/15 , 19 83 , that (I) (we) lost saw the deceased alive on 12/15 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE K.F. Cheyney | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/15/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K.F. CHEYNEY, M.D. | | | 22e. ADDRESS 18111 PRINCE PHILIP, OLNEY MD. 20832 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | | 23b. DATE 12/17/1983 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND, PRINCE GEORGE MD. | | |
| 24. FUNERAL HOME OR OTHER PLACE OF INTERMENT 232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

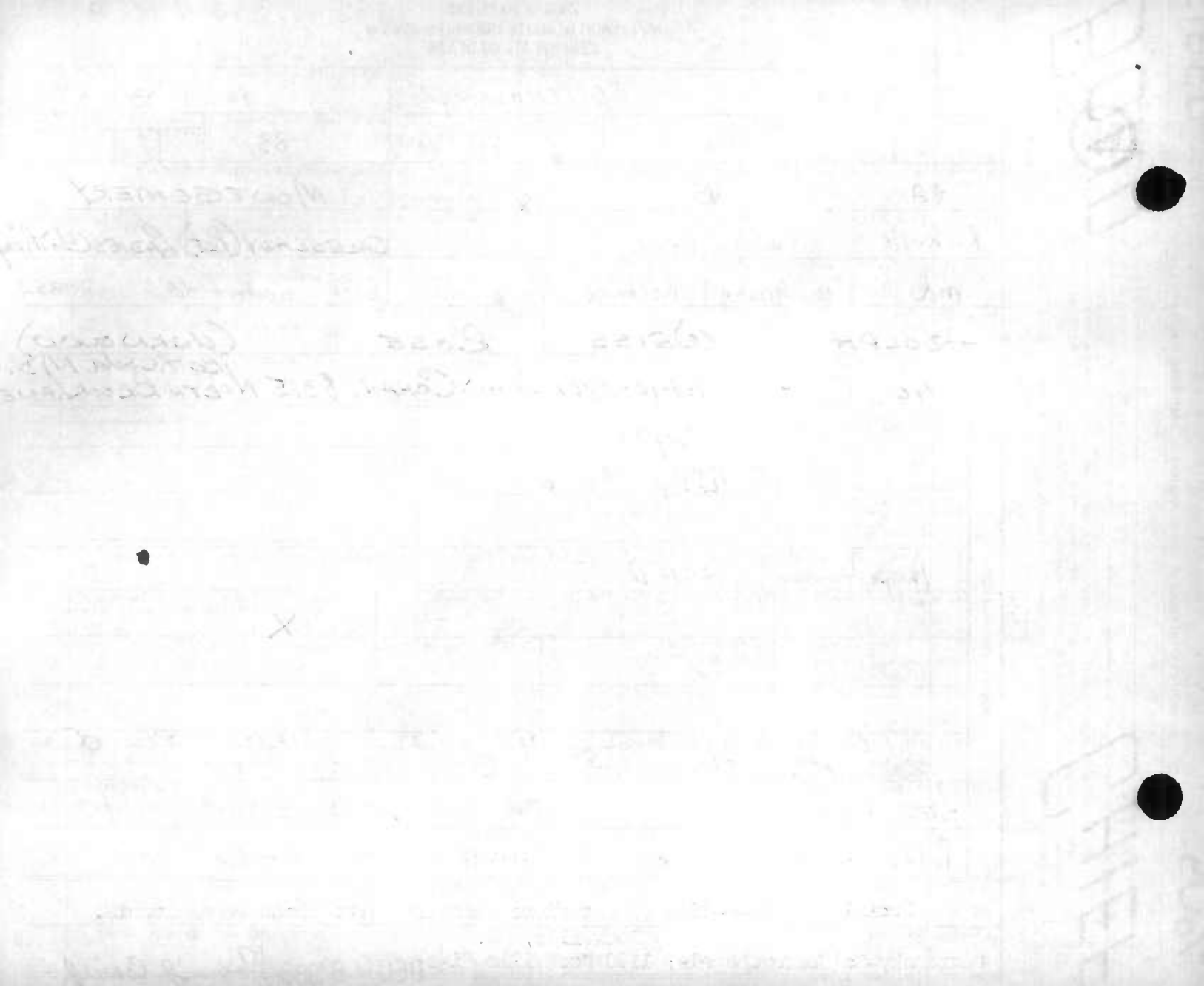
| | | | | | | | | | | | |
|---|--|---|-----------|---|------------------------------------|---|-------------------|--|-----|---|---|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| | | SARA | | | | OPPENHEIMER | 12 | 4 | 83 | | 3 ³⁰ PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | White | | 6 25 00 | | 83 | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| PA | | US | | | | MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF YEAR) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Rockville | | Hebrew Home | | | | | | SALESLADY (Ret) | | LADIES Clothing | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| md | | Montgomery | | Rockville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6125 Montrose Rd 20852 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | |
| ADOLPH WEISS | | | | ROSE (UNKNOWN) | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| NO | | - | | 161-10-3901 JOAN CONAN, 8315 NORTH BROOKLAND | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Septicemia | | | | | | | | | | | |
| 7078 | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) Deep ulcers | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| Hypertension, ASH D | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/ 19 83, to 12/4 19 83, the (we) last saw the deceased alive on 12/1 19 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| Peter Sherer | | | | MD | | | | 12/5/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| Peter Sherer MD | | | | 3947 Ferrara Dr. Wheaton MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | |
| Burial | | | 12-6-1983 | | Montefiore Cemetery | | | Fox Chase Pennsylvania. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME ADDRESS | | | | | | | | | | | |
| Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | | | DEC 8 1983 | | John J. Connel | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST John MIDDLE T. LAST Osborne | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| John T. Osborne, Sr. | | | | 12 4 83 | | 11 10 A M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| Male | White | July 8 1916 | | 67 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| New York | USA | | | Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Takoma Park | Washington Adventist Hospital | | | C & P Co. | | Retired | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | |
| Md. PG | | Hyattsville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 712 Cox Ave 20783 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST Thomas Osborne | | FIRST MIDDLE LAST Mary Yeager | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| Yes | | WWII | | 579 05 2659 Ozella L. Osborne (Wife) Same as Above | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1629
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) LIVER

DUE TO, OR AS A CONSEQUENCE OF

(c) BRONCHOGENIC CARCINOMA

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Hepatectomy, platelet deficiency (27,000)

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/4 1983 to 12/4 1983, that (I) (we) last saw the deceased alive on 12/4 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| Kenneth Cruze, MD | | MD. | | 12/4/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| Kenneth Cruze, MD | | 831 University Blvd. E S.S.Md. | | | | | |

| | | | | | | | |
|--|--|-----------|--|------------------------------------|--|----------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | 12/7/83 | | Cedar Hill Cemetery | | Suitland PG Maryland | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Hines/Rinaldi 11800 New Hamp. Ave. S.S.Md. | | | | DEC 5 1983 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Item 6 per call from F.H. 12.14/83 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|---|---|--|--|
| 1- FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Jacinta B Osorio</u> | | | | | 2a. DATE OF DEATH MONTH <u>12</u> DAY <u>9</u> YEAR <u>83</u> 2b. HOUR <u>8:30</u> P.M. | | | | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH MONTH <u>2</u> DAY <u>10</u> YEAR <u>03</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>80</u> - <u>87</u> = YRS. | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Peru</u> | | 9. CITIZEN OF WHAT COUNTRY? <u>Peru</u> | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD. | | | |
| 12. CITY OR TOWN OF DEATH <u>Takoma Park</u> | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington Adventist Hospital</u> | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u> | | 15. KIND OF BUSINESS OR INDUSTRY | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <u>Md.</u> 16b. COUNTY <u>Prince Georges</u> 16c. CITY OR TOWN <u>Hyattsville</u> | | 17. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 18. STREET ADDRESS <u>7888 Riggs Road</u> | | 19. ZIP CODE <u>20783</u> | | | |
| 14. FATHER'S NAME FIRST <u>Calistro</u> MIDDLE <u>Osorio</u> LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST <u>Francisca</u> MIDDLE <u>Boryas</u> LAST | | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 17. SOCIAL SECURITY NO. <u>577-82-8683</u> | | 18. INFORMANT ADDRESS <u>Wash. D. C.</u> | | 19. <u>Fortunata Candy Mesones</u> 1743 Irving St. N.W. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: 1830 IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ovarian Cancer with metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>11/2</u> , 19 <u>83</u> to <u>12/9</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/9</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>12/9/83</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. SMITH HO., M.D.</u> | | 22e. ADDRESS <u>8323 Haddon DR. Takoma PK MD.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>Dec. 13, 1983</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> | | 23d. LOCATION CITY OR TOWN <u>Washington, D. C.</u> COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR <u>DeVol Funeral Home, Inc.</u> NAME <u>James E. DeVol</u> ADDRESS <u>2222 Wisconsin Ave. N.W.</u> | | 25a. DATE REC'D. BY REGISTRAR <u>DEC 14 1983</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | |

Hartsville, P. D.

Hartsville

7501 River Road

Box 100

Rich, P. D.

77-1-100 2 The New York Times (Sept. 13) . . .

10, 17, 1957 Rock Creek Country, Washington, D. C.

Low, H. H., Inc., Inc.

Washington, D. C.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Geneva (AKA) Genevieve C. O'toole | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 24, 1983 | | 2b. HOUR
11:35 PM | |
| 3. SEX
Female. | 4. RACE
White. | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 22, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Penn. | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montg. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Chevy Chase Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Res. Mgr. Apts. | | 12b. KIND OF BUSINESS OR INDUSTRY
INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. 13b. COUNTY Montg. 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
Springdale Terrace | |
| 14. FATHER'S NAME
Edwin | | 15. MOTHER'S MAIDEN NAME
Ellen | | 16. MIDDLE Ruddy. LAST | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No. | | 16b. SOCIAL SECURITY NO.
187-18-0732 | | 17. INFORMANT
A. Richard H. Frobose. 7051 Carroll | |
| 16c. ADDRESS
Takoma Park. Md. | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Respiratory Arrest****3319**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Cerebral Atrophy**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-16-83 to 12-24-83 , that (I) (we) last saw the deceased alive on 12-16-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Christopher Unger | | | | DEGREE
MD. | | 22c. DATE SIGNED
12/25/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Christopher Unger | | | | 22e. ADDRESS
8218 Wis. Ave. Bethesda Md. 20814 | | | |

| | | | |
|--|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial. | 23b. DATE
12/28/83 | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | 23d. LOCATION
(CITY OR TOWN)
Silver Spring, Montg. Md. |
| 24. FUNERAL DIRECTOR
Takoma Funeral Home | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1983 | |
| 25b. REGISTRAR'S SIGNATURE
John E. Connel | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18b is marked, the medical examiner must be notified at once.

1941

Dec. 24, 1945

Geneva (W.A.) Genevieve C. O'Loone

51

Nov. 12, 1901

Alto.

Female

Kent.

U. S. A.

Tenn.

Noted Nov. 1945

Genevieve C. O'Loone

Genevieve C. O'Loone

Study.

Alto.

Alto.

Alto.

Genevieve C. O'Loone

1941-1945 A. O'Loone, 1941-1945

Genevieve C. O'Loone

Genevieve C. O'Loone

201

88

88

88

Genevieve C. O'Loone

Genevieve C. O'Loone

Genevieve C. O'Loone

Genevieve C. O'Loone

Genevieve C. O'Loone

Genevieve C. O'Loone

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Dennis Owens | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec 12, 83 | | | 2b. HOUR
9:25P M | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec 11, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Dickerson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
20500 Beallsville, Rd | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Trackman | |
| 12b. KIND OF BUSINESS OR INDUSTRY
B & O Railroad | | 13a. STATE
Md | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Dickerson | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
20500 Beallsville Rd, | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dennis Owens Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Martha Dorsey | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
Unk. | | 17. INFORMANT
ADDRESS
Mr Dennis Owens Jr(Son) 21101 White, s Ferry Rd
Poolesville, Md | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

1850

IMMEDIATE CAUSE (a)

Prostate Cancer

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

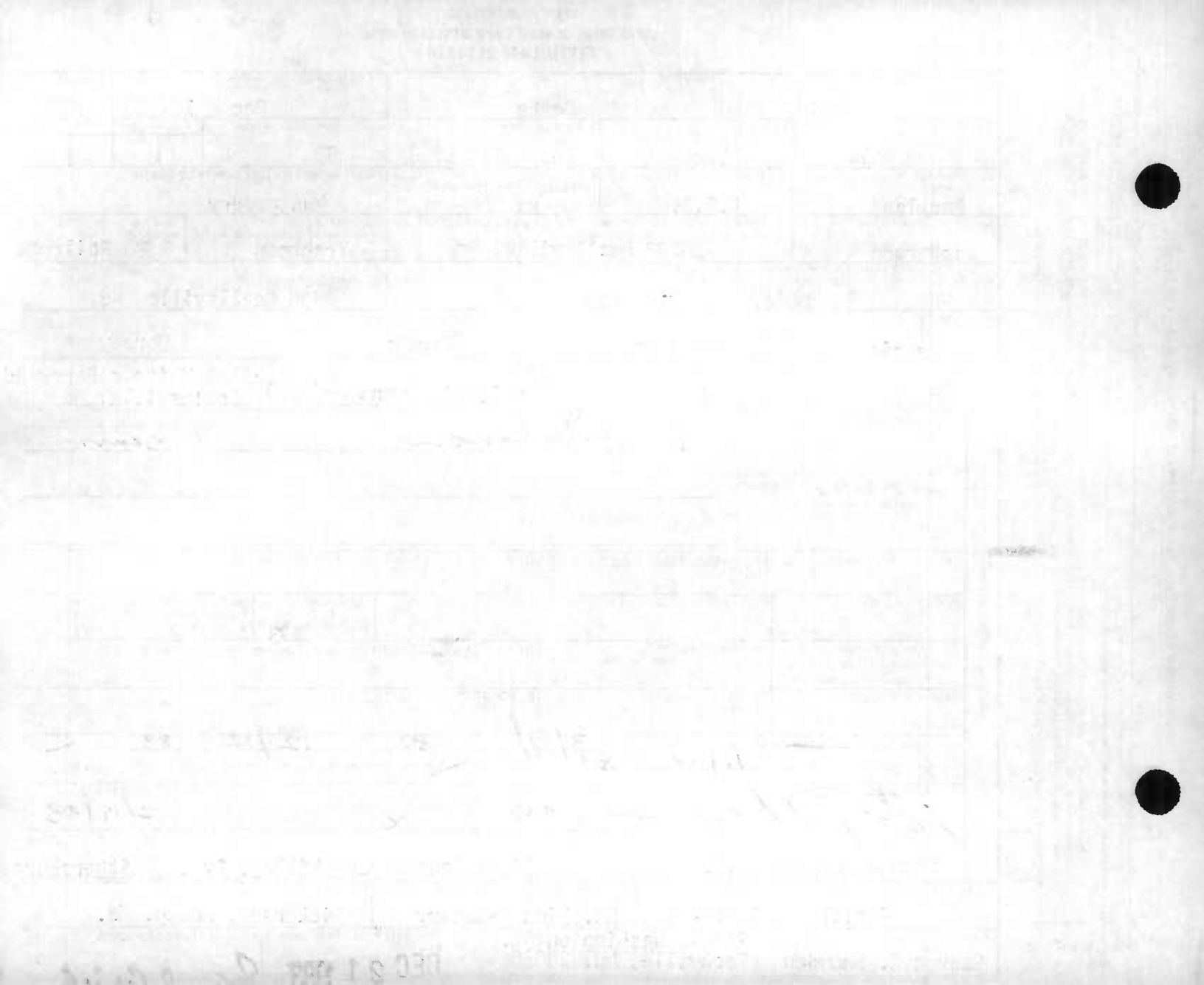
| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 3/7/80 to 12/12/83 , that (I) (we) last
saw the deceased alive on 11/18/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Stephen Newman | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/14/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stephen Newman, M.D. | | | | 22e. ADDRESS
19261 Monntgomery Village Ave., Gaithersburg Md. 20879 | | | |

| | | | | | | | |
|---|--|------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-16-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dickerson, Montg. Md. | |
| 24. FUNERAL DIRECTOR
NAME
George R. Snowden | | | | 24b. ADDRESS
246 N. Washington St.
Rockville, Md. 20850 | | 25a. DATE REC'D. BY REGISTRAR
DEC 21 1983 | |
| 25b. REGISTRAR'S SIGNATURE
John A. Baird | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CATHERINE F. PAINTER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-09-83 | | | 2b. HOUR
8:30 PM | | | |
| 3. SEX
FEMALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 25 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, DC | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SLIGO GARDENS N.H. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
11700 Old Columbia Pk. 20904 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Albert Johnson | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Germold | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
ADDRESS
Madge Askins-daughter-(same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1629
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic Carcinoma of the lung
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 7 , 19 83 , to Dec 9 , 19 83 , that (I) (we) lost
saw the deceased alive on Dec 8 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
MARK K. LI, M.D. | | | DEGREE | | | ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/09/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARK K. LI, M.D. | | | 22e. ADDRESS
1721 NW IV. BLVD WEST, S.S. MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Dec 12, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pr. Georges Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
HINES/RINALDI, F.H.
11800 NEW HAMPSHIRE AVE S.S. MD. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1983 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Anastasia Paleologos | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 18 83 | | | 2b. HOUR
12 ^m M | |
| 3. SEX
Female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 29 1886 | | 6. AGE (IN YEARS LAST BIRTHDAY)
97 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Greece | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sharon Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Brunzos | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNK Demitriou | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
ADDRESS
John Paleologos-son-(same as 13e) | | | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
4292 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr. | |
| DUE TO, OR AS A CONSEQUENCE OF
(b)
Cerebrorespiratory failure | | 6 mo | |
| DUE TO, OR AS A CONSEQUENCE OF
(c)
Arteriosclerotic CV Disease | | years | |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
Organic Brain Syndrome

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/15/83 to 12/17/83, that (I) (we) lost
saw the deceased alive on 12/15/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) saw the body after death. | | | | | | | |
| 22b. SIGNATURE
J. H. Light | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/18/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. H. Light | | | | 22e. ADDRESS
18111 P.P. Highway Dr Olney Md 20832 | | | |

| | | | | | | | |
|--|--|------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 20, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION
Rockville Montgomery Md. | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi Funeral Home | | 11800 N.H. Ave.,
S.S. Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 20 1983 | | | |
| | | | | REGISTRAR'S SIGNATURE
John J. Connel | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or advised.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

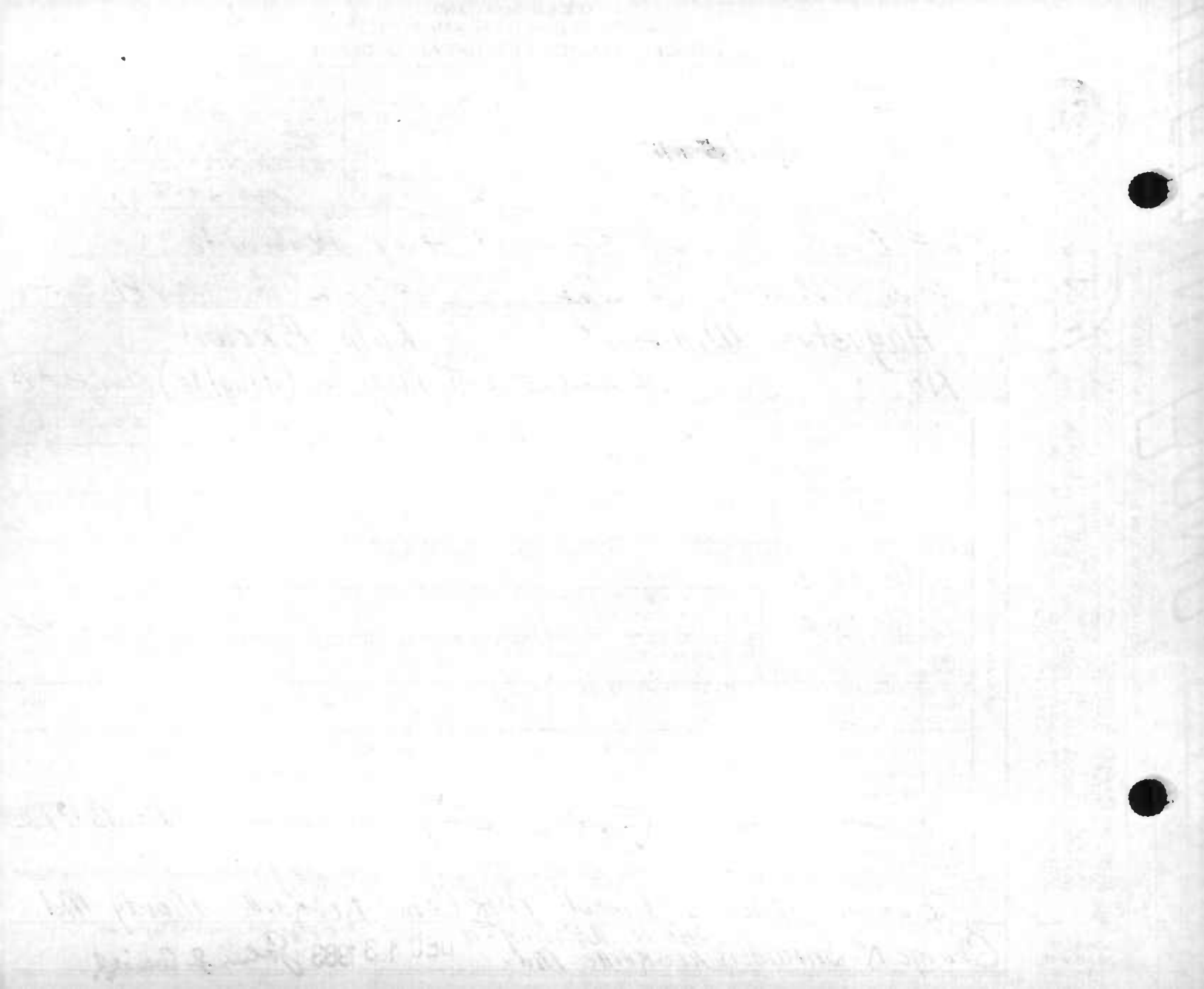
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|------------------|--|---|---|-------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) Irene Palmer | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR Dec 10 1983 | | |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH
MONTH DAY YEAR April 15 1912 | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 71 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | 10. CITY OR TOWN OF DEATH Rockville | | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Advent. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD. | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN Rockville | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Augustus Williams | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Lula Brown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 278-20-8025 | | 17. INFORMANT ADDRESS Betty Magruder (daughter) Same AS #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden myocardial infarct
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE John J. Carver | | TITLE (SPECIFY) Dep. | | DATE SIGNED Dec 10 1983 | |
| EXAMINER'S NAME (TYPE OR PRINT) George R. Snowden | | ADDRESS 246 N. Washington Rockville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12-15-83 | | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem. | |
| 23d. LOCATION (CITY OR TOWN) Rockville | | 23e. COUNTY Montg. | | 23f. STATE MD. | |
| 24. FUNERAL DIRECTOR
NAME George R. Snowden | | ADDRESS 246 N. Washington Rockville, Md. | | 25a. DATE REC'D. BY REGISTRAR DEC 13 1983 | |
| 25b. REGISTRAR'S SIGNATURE John J. Carver | | | | | |

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Flora Caroline Parisius</i> | | | 2a. DATE OF DEATH
MONTH <i>Dec</i> DAY <i>8</i> YEAR <i>1983</i> | | | 2b. HOUR
<i>10:55 P.M.</i> | | | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
MONTH <i>07</i> DAY <i>06</i> YEAR <i>95</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>88</i> | | IF UNDER 1 YEAR
MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN. <i></i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MINNESOTA</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery Co.</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>SHILSKIRAN HOSP</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Domestic</i> | |
| 13a. STATE
<i>MD.</i> | | | 13b. COUNTY
<i>MONTGOMERY</i> | | 13c. CITY OR TOWN
<i>SILVER SPRING</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST <i>CARL</i> MIDDLE <i>W.</i> LAST <i>SAUER</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST <i>BERTHA</i> MIDDLE <i>L.</i> LAST <i>GERBER</i> | | | 13e. STREET ADDRESS
<i>10000 BRUNSWICK AVE #418</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <i>No</i> | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>217-38-6602</i> | | 17. INFORMANT
ADDRESS
<i>4202 Amber Dr.
Kensington, Md 20815</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Sepsis</i>
<i>5621</i>
DUE TO, OR AS A CONSEQUENCE OF-
(b) <i>Diverticulitis of colon</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<i>Obstructive pulmonary disease</i> | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>None</i> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>None</i> | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
<i></i> | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
<i></i> | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i></i> | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Nov</i> 19 <i>66</i> , to <i>present</i> 19 <i></i> , that (I) (we) last saw the deceased alive on <i>Dec. 8</i> 19 <i>83</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23a. SIGNATURE
<i>John B. Umhou</i> MD | | | | | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>12/9/83</i> | |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>John B. Umhou</i> MD | | | | | | 22e. ADDRESS
<i>8805 Conn. Ave., Chevy Chase Md</i> | | | |
| 23c. BURIAL, CREMATION, REMOVAL
<i>Burial</i> | | | 23d. DATE
<i>12-12-83</i> | | 23e. NAME OF CEMETERY OR CREMATORY
<i>St. John's Lutheran Cem</i> | | 23f. LOCATION
CITY OR TOWN COUNTY STATE
<i>Columbia THAWES MD</i> | | |
| 24. FUNERAL DIRECTOR
NAME
<i>SLACK Funeral Home</i> | | | | | | ADDRESS
<i>20. BOX 268</i> | | 25. DATED BY REGISTRAR
<i>DEC 12 1983</i> | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Canfield</i> | | | |

1. The first part of the report is a general description of the project and its objectives. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

2. The second part of the report is a detailed description of the methodology used in the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

3. The third part of the report is a detailed description of the results of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

4. The fourth part of the report is a detailed description of the conclusions of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

5. The fifth part of the report is a detailed description of the recommendations of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

6. The sixth part of the report is a detailed description of the conclusions of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

7. The seventh part of the report is a detailed description of the recommendations of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

8. The eighth part of the report is a detailed description of the conclusions of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

9. The ninth part of the report is a detailed description of the recommendations of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

10. The tenth part of the report is a detailed description of the conclusions of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|---|--|---|--|--------------------------------------|--|---|--|
| 1. FOR
STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
WALTER Howard PARKEN Jr. | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 25, 1983 | | | 2b. HOUR
1:21 PM | | |
| 3 SEX
Male | | 4 RACE
white | | 5 DATE OF BIRTH
MONTH DAY YEAR
Jan. 4, 1946 | | 6 AGE (IN YEARS LAST BIRTHDAY)
37 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Brazil | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mont. General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Research Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
Government | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. 20872 | | | | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Damascus | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Walter H. Parken Sr. | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Elizabeth Ferris | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
140-36-6835 | | 17. INFORMANT
ADDRESS
Judith L. Parken Same as # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) CARDIAC ARREST
3989
DUE TO, OR AS A CONSEQUENCE OF
(b) RHEUMATIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) 20 YRS.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
POST-OPERATIVE MITRAL + AORTIC VALVE REPLACEMENTS | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1973 to 12-25 19 83 that (I) (we) last saw the deceased alive on 12-20 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Herbert L. Tanenbaum MD | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/25/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Herbert L. Tanenbaum | | | | 22e. ADDRESS
Bethesda, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | 23b. DATE
DEC. 26, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879 | | | | | | 25. DATE REC'D. BY REGISTRAR
DEC 29 1983 | | | | |
| 25b. REGISTRAR'S SIGNATURE
James J. Gainer | | | | | | | | | | |

BP



Handwritten text at the bottom of the page, possibly a signature or date, appearing as "DEC 20 1911".

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARIA C PATTYSON | | | 2a. DATE OF DEATH
MONTH 12 DAY 23 YEAR 83 | | | 2b. HOUR
7:31 P.M. | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH 7 DAY 25 YEAR 24 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Guatemala | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Silver Spring | | 13c. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
8819 Lanier Drive | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | Zip: 20910 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
578-42-5955 | | 17. INFORMANT (Husband) ADDRESS
8819 Lanier Dr. Paul L. Pattyson Silver Spring, MD | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Liver Failure****3030**

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Chronic Alcohol Intake**

DUE TO, OR AS A CONSEQUENCE OF

(c) APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**3 weeks**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **none**

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
 | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR 19
P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)
 | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
 | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Dec 7 , 19 83 , to Dec 23 , 19 83 , that (2) (we) last
saw the deceased alive on Dec 23 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (3) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Raymond Bass MD | | | | DEGREE
MD | | 22c. DATE SIGNED
12-24-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAYMOND BASS | | | | 22e. ADDRESS
3929 Ferrara Dr. Wheaton 20906 | | | |

| | | | | | | | |
|--|--|-----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
Dec. 27, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery Brentwood | | 23d. LOCATION
CITY OR TOWN Maryland COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR DEC 30 1983 25b. REGISTRAR'S SIGNATURE | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | HOURS MIN. | |
| FIRST MIDDLE LAST
Hester ANN PEARSON
Hester Pearson | | 12 10 83 | | 8 15 M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS (LAST BIRTHDAY)) | IF UNDER 1 YEAR
MONTHS DAYS | |
| Female | Caucasion | MONTH DAY YEAR
Oct. 7, 1895 | 88 YRS | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Virginia | U.S.A. | | Montgomery County MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Takoma Park | Washington Adventist Hospital | | Retired | | Homemaker |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Maryland | Montgomery | Berwyn Hts | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 5707 Seminole St. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST
Joseph Pearson | | FIRST MIDDLE LAST
Mary A. Vogt | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | N/A | | Leonard Tolson | |
| | | 578 244 202 | | ADDRESS
Route 2, Box 1233
Stanford, Virginia | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Pneumonia*2900
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *Generalized coarctation*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Senile dementia*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

*days**months**years*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:

Uterine tract infection with indwelling Foley catheter

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>12/5</u> , 19 <u>83</u> , to <u>12/10</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>12/9</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED | |
| <i>Byrl D. Johnson</i> | MD | 12/10/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | |
| BYRL D. JOHNSON | 4404 Queensbury Rd. Riverdale, Md. | | |

| | | | |
|--|-------------------|------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE |
| Burial | December 12, 1983 | Rock Hill Cemetery | Rock Hill, Stafford, Virginia |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| Lee Funeral Home, Inc. | | DEC 15 1983 | <i>John G. Connel</i> |
| 6638 Old Alexander Ferry Road, Clinton, Maryland | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic events, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| Item 19b film 587 cn
FOR
1- STATE 1-30-84 cn
REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Richard B Pemberton | | | | 2a. DATE OF DEATH
MONTH 12 DAY 6 YEAR 83 | | | | 2b. HOUR
7:45A.M. | | | |
| 3 SEX
male | | 4 RACE
Caucasian | | 5. DATE OF BIRTH
MONTH 5 DAY 11 YEAR 21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (COUNTRY)
Oklahoma | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp. | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales Manager | | 12b. KIND OF BUSINESS OR INDUSTRY
Self-employed | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
11700 Old Columbia Pike 20904 | | | | | |
| 14. FATHER'S NAME
FIRST Harold MIDDLE E. LAST Pemberton | | | | 15. MOTHER'S MAIDEN NAME
FIRST Dottie MIDDLE E. LAST Simmons | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) yes (IF YES, GIVE WAR OR DATES) WW II | | | | 16b. SOCIAL SECURITY NO.
081-16-0616 | | 17. INFORMANT
ADDRESS
Vivian S. Pemberton-wife-(same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal Failure
1509
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Septic shock
DUE TO, OR AS A CONSEQUENCE OF
(c) gastrointestinal fistula | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Cerebral aneurysm | | | | | | | | | | | |
| 19a. DATE OF OPERATION
10/20/20/21 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Esophageal atresia | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/19 19 82 to 12/6 19 83 , that (I) (we) last saw the deceased alive on 12/5 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Barry J. Levin | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/6/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARRY J. LEVIN | | | | | | 22e. ADDRESS
4801 MASS AVE, N.W. WASH, D.C. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Dec. 7, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Lees' Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, DC | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi Funeral Home | | | | ADDRESS
11800 N.H. Ave., Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 7 - 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Conner | | | |

My dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the application for a patent for the invention of a new and improved method of producing artificial silk, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Yours very truly,
J. H. ...
Director

RECEIVED
JAN 11 1898

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked "at work", it shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ROBERT G. PENDLETON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DEC 25, 1983 | | | 2b. HOUR
5:45 P M | | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 24, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
13916 Blair Stone Lane | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Hardware Stor | | 12b. KIND OF BUSINESS OR INDUSTRY
Self-Employed | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
13916 Blair Stone Lane 20906 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John R. Pendleton | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marie N. Massey | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(S, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | 16b. SOCIAL SECURITY NO.
579-10-9155 | | 17. INFORMANT
ADDRESS
Ruth H. Pendleton Wife Same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RENAL CELL CARCINOMA
1890
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 1/2 YRS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 19 83 to Dec 25, 19 83 , that (I) (we) last saw the deceased alive on Nov 27, 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Eugene P. Flannery MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
26 Dec 83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EUGENE P. FLANNERY, MD | | | | | | 22e. ADDRESS
18111 PRINCE PHILIP DR.
OLNEY, MD. 20832 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Dec. 29, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Montgomery Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 28 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Lohr | | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | | | | | | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Florence GROSSMAN Philips | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 19, 1983 | | 2b. HOUR
5 P |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
APR. 17, 1900 | 6. AGE (IN YEARS (LAST BIRTHDAY))
83 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
OWNER | 12b. TYPE OF BUSINESS OR INDUSTRY
PHOTOGRAPHY POLICE EQUIP. CO. | |
| 13a. STATE
MARYLAND | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
SILVER SPRING | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
11200 LOCKWOOD DR., APT. 420 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM GROSSMAN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY WE ISSAGER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
578-52-5904 | | 17. INFORMANT
MRS. SANDRA PYLE
ADDRESS
9222 MELLENBROOK RD. COLUMBIA, MD 21045 |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4100

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) **Acute myocardial infarction**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**minutes****24 hours**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Chronic obstructive lung disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐

AT WORK AT WORK

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from **12/18** 19**83**, to **12/19** 19**83**, that (I) (we) last
saw the deceased alive on **12/19** 19**83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING

MEDICAL

STAFF

PHYSICIAN ☒DIRECTOR ☐PHYSICIAN ☐

22c. DATE SIGNED

12/19/83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

Alan Weinstein MD**1299 Lumberton Ave Silver Spring MD**23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) **BURIAL**23b. DATE
DEC. 21, 198323c. NAME OF CEMETERY OR CREMATORY
MOGAN ABRAHAM23d. LOCATION
CITY OR TOWN
ROSEDALECOUNTY
BALTO.STATE
MD24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC.

25a. DATE REC'D. BY REGISTRAR

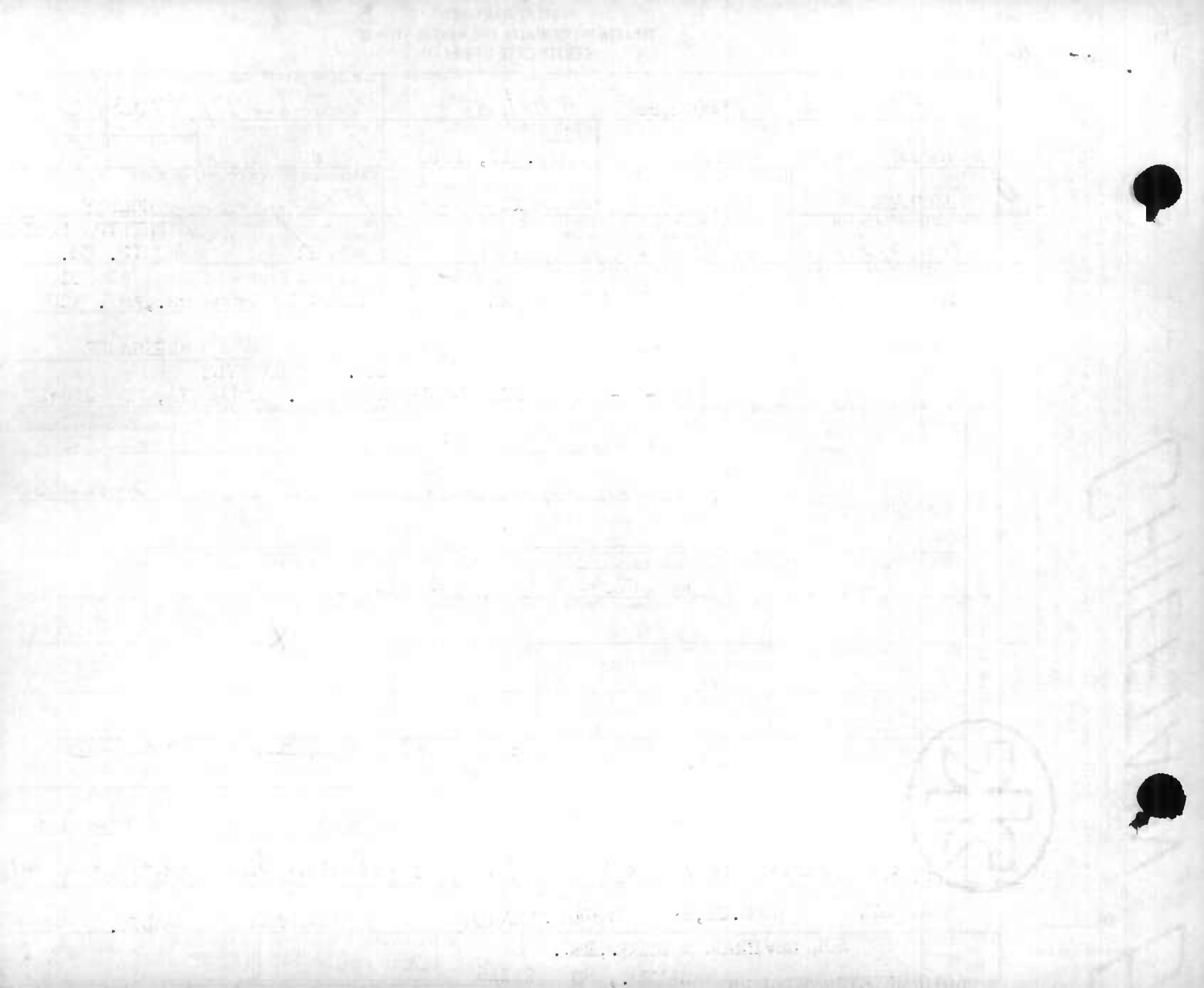
25b. REGISTRAR'S SIGNATURE

6010 BELTSTREET BALTO., MD 21215**DEC 29 1983****[Signature]**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.



PHILLIPS
JAMES

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James Maurice Phillips | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 18 83 | | | 2b. HOUR
12:16pm | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 15 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PLASTERER | | 12b. KIND OF BUSINESS OR INDUSTRY
hospital | |
| 13a. STATE
Maryland | | 13b. COUNTY
Mont | | 13c. CITY OR TOWN
Takoma Park | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
112 Elm Avenue 20912 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES F. PHILLIPS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SARAH JANE GIDDINGS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES
N/A | | 16b. SOCIAL SECURITY NO.
577 30 6927 | | 17. INFORMANT
ADDRESS
RICHARD M. PHILLIPS - 415 ELM AVE T.P. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
4140
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC HEART DISEASE
YEARS
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
— | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
ADRENAL INSUFFICIENCY | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
— | | | | | |
| 21d. INJURY OCCURRED
WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
— | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
— | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/18/83 to 12/18/83, that (I) (we) last saw the deceased alive on 12/18/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Arnold G. Levy MD | | | | DEGREE
— | | | | 22c. DATE SIGNED
12-18-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ARNOLD G. LEVY, MD | | | | 22e. ADDRESS
1106 SPRING ST.
SILVER SPRING MD. 20910 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 21, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
St. John's Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
Takoma Funeral Home 299 Madison | | | | ADDRESS
254 Carroll N.W.H.D. | | 25a. DATE REC'D. BY REGISTRAR
DEC 21 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carls | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21

Handwritten notes and a table at the top of the page. The table has several columns and rows, with some text written inside the cells. The handwriting is somewhat faded and difficult to read.

Handwritten notes in the middle section of the page, continuing the text from the top. The text is written in a cursive style.

Handwritten notes in the lower middle section of the page. The text is more sparse and appears to be a continuation of the previous sections.

Handwritten notes at the bottom of the page. The text is very faint and difficult to decipher, but appears to be a conclusion or summary of the document.

CHIEF

2001

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (1))
20M 4/82

| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|----------|--|--|--|--|--|--|--|--------------------------------------|--|------------------|--|--------------------------|--|----------|--|-----------|--|--------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | FIRST | | | | | | | | | | MIDDLE | | | | | | | | | | LAST | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | | | | | | | | | | | | | | | | |
| Sinclair | | | | | | | | | | J. | | | | | | | | | | Pinnick | | | | | | | | | | DATE KNOWN OF DEATH | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | | | | | | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | | | | | | | | | | | | |
| M | | | | | | | | | | W | | | | | | | | | | Feb 17 01 | | | | | | | | | | 82 | | | | | | | | | | MONTHS | | DAYS | | HOURS | | MIN | | 12 5 1983 | | 6:03P | | | | | | | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED | | | | | | | | | | NEVER MARRIED | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | MD | | | | | | | | | | | | | | | | | |
| OHIO | | | | | | | | | | U.S.A | | | | | | | | | | WIDOWED | | | | | | | | | | DIVORCED | | | | | | | | | | Montgomery | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Olney | | | | | | | | | | Montgomery General Hospital | | | | | | | | | | ENGINEER - LONG LEASE | | | | | | | | | | Food Products | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | | | | | | | | 13e. STREET ADDRESS | | | | | | | | | | | | | | | | | | | |
| Md | | | | | | | | | | Mont. | | | | | | | | | | D. C. Spg | | | | | | | | | | YES | | | | | | | | | | NO | | | | | | | | | | 15513 Wembrough St | | | | | | | | | |
| 14. FATHER'S NAME (FIRST) | | | | | | | | | | MIDDLE | | | | | | | | | | 15. MOTHER'S MAIDEN NAME (FIRST) | | | | | | | | | | MIDDLE | | | | | | | | | | LAST | | | | | | | | | | | | | | | | | | | |
| ? | | | | | | | | | | PINNICK | | | | | | | | | | NOT AVAILABLE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | 174-09-1250 | | | | | | | | | | ROBERT E. PINNICK | | | | | | | | | | 15513 WEMBROUGH ST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | PART I DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9505 | | | | | | | | | | IMMEDIATE CAUSE (a) Brain Damage | | | | | | | | | | 2 days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | (b) Cardio Pulmonary Arrest | | | | | | | | | | 2 days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | (c) Overdose & asphyxiation | | | | | | | | | | 2 days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | | None | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| None | | | | | | | | | | | | | | | | | | | | YES | | | | | | | | | | NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | P.M. 123 19 83 | | | | | | | | | | Overdose & placed in bag over head | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK OR NOT WHILE AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 21f. LOCATION (CITY OR TOWN, STREET, COUNTY, STATE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOT WHILE AT WORK | | | | | | | | | | Home | | | | | | | | | | Wembrough St. D. C. Spg Mont. Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | | | | | | | | | Autopsy | | | | | | | | | | Inspection | | | | | | | | | | Inquiry | | | | | | | | | | and in my opinion | | | | | | | | | | | | | | | | | | | |
| Natural causes | | | | | | | | | | Accident | | | | | | | | | | Suicide | | | | | | | | | | Homicide | | | | | | | | | | Undetermined manner | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | M.D. | | | | | | | | | | MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (CITY OR TOWN, COUNTY, STATE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | Dec 12, 1983 | | | | | | | | | | Mt. Vernon Memorial Garden | | | | | | | | | | Mt. Vernon Ohio | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | | | | | | 25. DATE RECD BY REGISTRAR | | | | | | | | | | REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Taverny Funeral Home | | | | | | | | | | 254 Penn St NW DC | | | | | | | | | | DEC 9 1983 | | | | | | | | | | John J. Calvert | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

424

1000

10-10-1000

10-10-1000 Robert A. Jones - 1000

10-10-1000 Robert A. Jones - 1000

Item 19a Film 587 1-19-84
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|------------------------------|---|---|--|--------------------------------------|--|-----------------|-----------------------------------|-----------------|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| Jean | | y. | | Pogost | 11-10-83 | | | | | 625 PM | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Female | White | | MONTH DAY YEAR
1 10 10 | | 73 YRS. | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| IOWA | U. S. A. | | | | Montgomery MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Takoma Park | | WASHINGTON ADVENTIST HOSPITAL | | | | SECRETARY | | PUBLISHING CO. | | | |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 15. INSIDE CITY LIMITS? | | 13a. STREET ADDRESS | | 13b. STREET ADDRESS | | | | | |
| Maryland | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 7333 New Hampshire Ave., #506 | | 20783 | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| Abraham | | Belle | | Braunstein | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 6347 Fresh | | | | | |
| No | | 579-40-1891 | | William L. Siegle | | Pittsburgh, Pa. 15217 | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a): <u>Cardiac Failure</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: | | | | | | | | | | | |
| (b) <u>Sepsis - Pulmonary</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) <u>Pneumonia</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | | |
| <u>Renal Failure</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 10-21-1983 | | Carcinoma of Rectum | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 18; PART 1 OR PART 2) | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from 19 to 11/10/83, that (i) (we) last saw the deceased alive on 11/10/83, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (2) (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | |
| H. L. MARTER | | | | 11/10/83 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| H. L. MARTER | | 831 University Blvd. E. - Silver Spring | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| Burial | | 11/13/1983 | | Beth Shalom Cong. Cemetery | | Capitol Heights, Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | 24b. DATE REC'D. BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | | | | | | | |
| Donald M. Stein Hebrew Memorial F. H. | | NOV 17 1983 | | Spencer G. Galt | | | | | | | |
| 232 Carroll Street, N. W. Washington, D. C. | | | | | | | | | | | |



[Faint handwritten signature]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|---|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SAMUEL POMS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 11, 1983 | | 2b. HOUR
8:00a.m. | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 1, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Poland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
7425 Democracy Boulevard | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Owner (Ret.) | | 12b. KIND OF BUSINESS OR INDUSTRY
Auto Body Repair | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7425 Democracy Boulevard | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Abraham Poms | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Libby (unknown) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
578-44-1713 | | 17. INFORMANT
ADDRESS
Bethesda, Md.
Frieda Poms; 7425 Democracy Boulevard | | | | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4140
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary Heart Disease - heart failure
DUE TO, OR AS A CONSEQUENCE OF
(c) 20 yrs | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Immediate |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Chronic obstructive lung disease; chronic renal failure**

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April , 19 83 , to December , 19 82 , that (I) (we) lost
saw the deceased alive on 12/15 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
[Signature] MD | | | | 22c. DATE SIGNED
12-11-1983 | | 22d. ADDRESS
ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Gerald I. Shugoll, M.D. | | | | 22f. ADDRESS
5530 Wisconsin Ave., Washington, D.C. | | | |

| | | | | | | | |
|--|--|--------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12-12-1983 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Gdn. Falls Cgurch, Virginia | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 12 1983 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|---|--|--|--|--|--|--------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
PEARL | | MIDDLE
E. | | LAST
POWANDO | | 2a. DATE OF DEATH | | MONTH
DEC 4 | | YEAR
1983 | | 2b. HOUR
10 40 | | M
M | |
| 3. SEX
FEMALE | | 4. RACE
White. | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 27 09 | | | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Washington D. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery. MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital. | | | | | | | | 12a. USUAL OCCUPATION
(TYPE OF BUSINESS, SERVICE, OR VOCATION)
Retired. C. and P. | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Telephone. CO. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY
Maryland. F. Geo. | | 13b. CITY OR TOWN
Hyattsville. | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
7604 West Pk. Ave. 783 | | | | | | | | | | | |
| 14. FATHER'S NAME
Denri's A. McInerney. | | | | 15. MOTHER'S MAIDEN NAME
Annie Donnelly. | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, IF UNKNOWN) | | 16b. SOCIAL SECURITY NO.
No. | | 17. INFORMANT
Mrs. C. E. Kilpatrick. 7427 25 th Ave. Hyattsville. Md. | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
4148
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Ischemic Cardiomyopathy & LV Anemysm</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Cardiac arrhythmia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Hypertension</u> | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11/10/83</u> 19 <u>83</u> , to <u>12/4/83</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/3/83</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
<u>Vivek C. Vaid</u> | | | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/4/83 | | | | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)
Vivek C. Vaid M.D. | | | | | | | | 23b. ADDRESS
7676 New Hampshire Ave | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial. | | | | 23b. DATE
Dec. 7, 1983 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National. Arlington. Va. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR
<u>R. Walter Valters</u> | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 7 1983 | | | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Conner</u> | | | | | |

BP

77

Takoma Funeral Home Inc.
Dec. 7 1983
Arlington National, Arlington, Va.

Donna A. McInerney, Annie Donnelly,
Maryland, P. O. Box 1700 West 8th Ave.
Washington D. C. 20006
Montgomery, Maryland, P. O. Box 1700 West 8th Ave.
No. 1700 West 8th Ave.

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

 1- FOR
 STATE
 REGISTRAR

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Esther M. Quaid</u> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>Dec 15, 1983</u> | | 2b. HOUR
<u>10:15</u> M. |
| 3. SEX
<u>FEMALE</u> | 4. RACE
<u>WHITE</u> | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>OCT. 26 1896</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>87</u> YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>WASHINGTON DC</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery Co.</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>Silver Spring Md.</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Holy Cross Hosp.</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>NATIONAL ED. ASSOC.</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>(RETIRED)</u> |
| 13a. USUAL RESIDENCE (GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY
<u>D.C. 11</u> | | 13b. CITY OR TOWN
<u>WASHINGTON</u> | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE
<u>5611 SECOND ST. NW 99989</u> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>ELIAS</u> <u>DAKIN</u> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>MARY E. SUTTON</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>NO</u> | | 16b. SOCIAL SECURITY NO.
<u>578-32-2996</u> | | 17. INFORMANT
ADDRESS
<u>MARY FRANCIS QUaid - 5611 2nd ST. NW DC</u> | |

 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RESPIRATORY FAILUREAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH2+ Hours
 Conditions, if any, which
 gave rise to immediate
 cause (a), stating the
 underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) PNEUMONITIS

DUE TO, OR AS A CONSEQUENCE OF

(c)

4 DAYS

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Cerebrovascular Thrombosis

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION
<u>August 19 72</u> | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>RESECTION</u> | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR, A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August 19 72</u> to <u>DECEMBER 15 19 83</u> , that (I) (we) lost
saw the deceased alive on <u>DECEMBER 15 19 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Dennis J. Hand MD</u> | DEGREE
<u>MD</u> | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
<u>12/16/83</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>DENNIS J. HAND MD</u> | | 22e. ADDRESS
<u>4601 CONNECTICUT AVE NW. WASHINGTON DC 20008</u> | |

| | | | |
|---|----------------------------------|--|--|
| 23a. BURIAL, CREMATION REMOVAL
(S) <u>Burial</u> | 23b. DATE
<u>Dec. 19-1983</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Coringdon Memorial Cemetery</u> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Coringdon 11A</u> |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<u>Takoma Funeral Home, 5711 25th Ave NW DC</u> | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
<u>DEC 23 1983 [Signature]</u> | |

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Copyright Clearance Center

December 12 82 - 15 - 12 December 12 82

(1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100)

25/10/21

U.S. CONFIDENTIAL NO FOR DISSEMINATION

Medical Examiner notified and approved
Dr. John Tauber

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 is checked, any injury, or other traumatic event, the medical examiner must be notified andSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|---|---|-------------------------------------|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HAROLD G. QUASE | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/5/83 | | | 2b. HOUR
0152 AM | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
August 7 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Stacy Grove Adventist Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Physician | | 12b. KIND OF BUSINESS OR INDUSTRY
Medicine | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Potomac | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Hiram Quase | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Graff | | | 13e. STREET ADDRESS / ZIP CODE
2613 Oakenshield Drive, zip 20854 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
577 46 6551 | | 17. INFORMANT ADDRESS
Ruth H. Quase -wife- see # 13 | | | | | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4149 Cardiac Arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr. | |
| IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | DUE TO, OR AS A CONSEQUENCE OF (c) | |

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
None | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 1 19 81 to Sep 16 19 83 , that (I) (we) lost
saw the deceased alive on Sep 16 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Kenneth M. Keane | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/5/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Kenneth M. Keane M.D. | | 22e. ADDRESS
3900 Rodman Road, University Pk. 20834
Georgetown University Hospital, Washington, D.C. | | | | | |

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 8, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | ADDRESS
Funeral Homes,
P.A. Rockville, Maryland | | 25a. DATE REC'D. BY REGISTRAR
DEC 7 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Tauber | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
AUDREY JUANITA RACHFORD | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 6 1983 | | 2b. HOUR
7:25 P_M |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 31 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED manager | | 12b. KIND OF BUSINESS OR INDUSTRY
apt complex |
| 13a. STATE
MARYLAND | 13b. COUNTY
PRINCE GEO'S | 13c. CITY OR TOWN
BELTSVILLE | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
4516 USANGE STREET 20705 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
THOMAS ISAAC BURTON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LAVOLDA PAULINE BOYLE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
219-12-4512 | | 17. INFORMANT
ADDRESS
NANCY P. SWEENEY, 4516 USANGE STREET, | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
0389
IMMEDIATE CAUSE (a) SEPSIS & PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **NO**

MEDICAL CERTIFICATION

| | | | |
|---|--|---|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 16 , 19 83 , to DECEMBER 6 , 19 83 , that (I) (we) lost
saw the deceased alive on DECEMBER 6 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
R. L. Sollock | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
7 DEC 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. L. SOLLOCK, LCDR, MC, USN | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | |

| | | | |
|--|-----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Dec., 9, 1983 | 23c. NAME OF CEMETERY OR CREMATORY
George Washington Cem | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Adelphi, Maryland |
| 24. FUNERAL DIRECTOR
NAME Donaldson Funeral Home, Laurel, Md | | 25a. DATE REC'D. BY REGISTRAR DEC 14 1983 25b. REGISTRAR'S SIGNATURE J. J. Connel | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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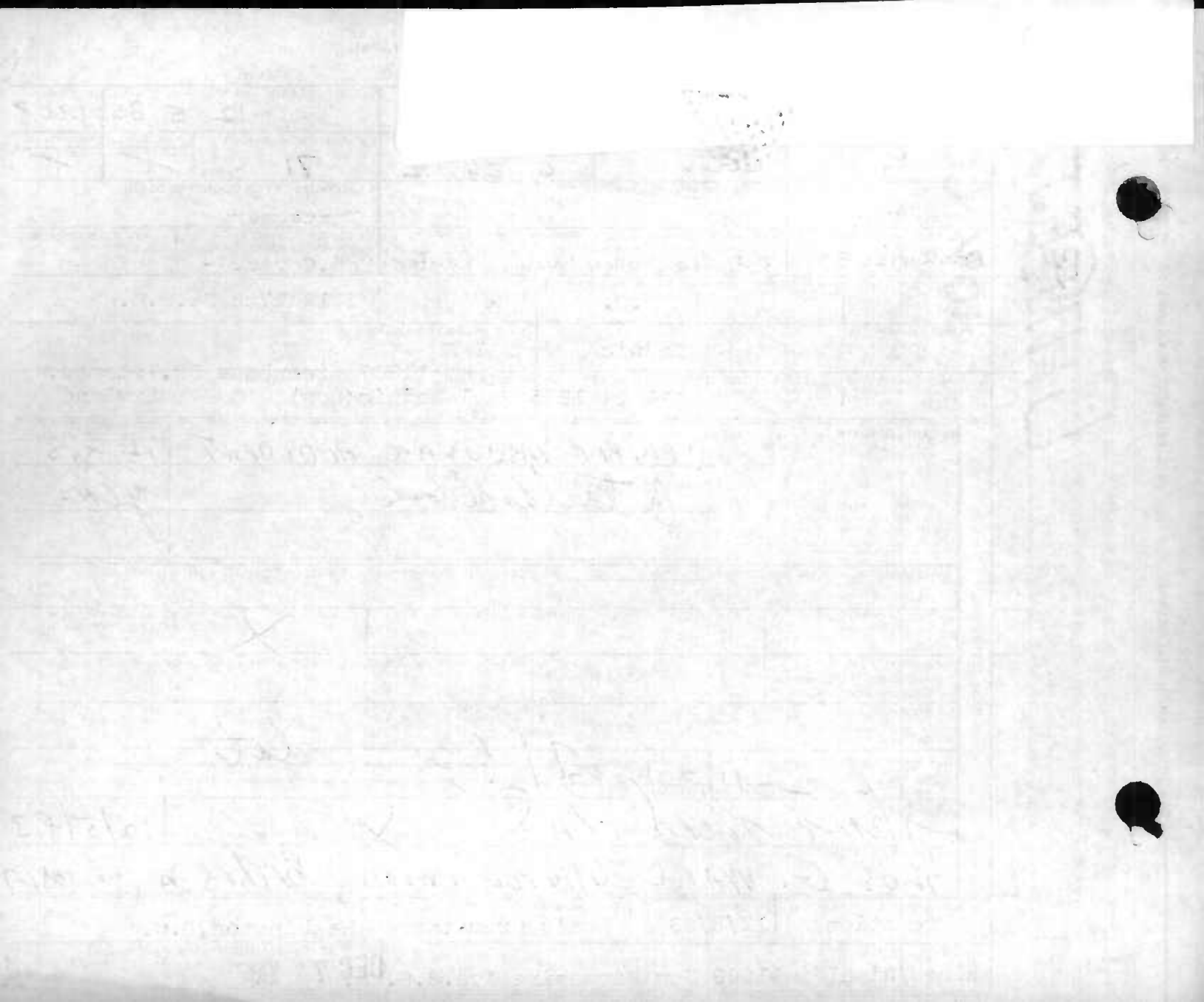
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|----------------------------------|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) John Rajnic | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 5 83 | | | 2b. HOUR
1:30 P M | | | | | |
| 3. SEX
M | | 4. RACE
Slav | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 24 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
1 1 | | 8. IF UNDER 24 HRS
HOURS MIN.
1 1 | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 9b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Potomac Valley Nursing Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Fed. Gov't.-- | | | 12b. KIND OF BUSINESS OR INDUSTRY
Engineer | | |
| 13a. STATE
MD | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
D.C. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2812 27th St. N.W. 99999 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNK Rajnic | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNK | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
111 24 1275 | | | 17. INFORMANT
11707 Greenhane Dr. Potomac, Maryland
Paul Rajnic (Son) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4360 C. Cerebro-vascular Accident
IMMEDIATE CAUSE (a) C. Cerebro-vascular Accident
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerosis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 1/2 yrs | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
11 19 83 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
Auto | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
1129 P St | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
6116 Robinwood, Bethesda, Md 20817 | | | | | |
| 22a. I certify that I (this hospital) attended the deceased from 11/29/83 to 12/5/83 , that I (we) lost saw the deceased alive on 11/29/83 , and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death) | | | | | | | | | | | |
| 22b. SIGNATURE
Thos G. Ward | | | | | | 22c. DATE SIGNED
12/5/83 | | | 22d. ADDRESS
6116 Robinwood, Bethesda, Md 20817 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
12/8/83 | | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hines/Rinaldi 11800 New Hampshire Ave. S.S. Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DEC 7 - 1983 John J. Connel | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|---|---|---|---|--|--|-------------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Charles L. Rankin</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>12-1-83</i> | | | 2b. HOUR
<i>10 PM</i> | | | |
| 3. SEX
<i>m</i> | | 4. RACE
<i>w</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>9 25 83</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>90</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Penn</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery CO</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Sm NH</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Ret. Painter</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>-</i> | |
| USUAL RESIDENCE (IF MAKING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE CITY OR TOWN
<i>Md. Pr. Geo. New Carrollton</i> | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>5900- Westbrook Dr. 20784</i> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>Chark Rankin</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Maggie McClay</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>210-07-2163</i> | | 17. INFORMANT ADDRESS
<i>Charles R. Rankin (above address) (Son)</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
<i>4379 CEREbroVASCULAR INSUFFICIENCY</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>4 YEARS</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<i>SENILE INANITION</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
<i>19</i> | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M.</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from <i>March 3, 1982</i> to <i>Dec 1, 1983</i> , that (b) (we) lost saw the deceased alive on <i>Dec 1, 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (If (we) (did) not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Martin C. Shargel</i> | | | | | DEGREE
<i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>1 Dec 83</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>MARTIN C. SHARGEL</i> | | | | | 22e. ADDRESS
<i>3720 PARLAGUT AVE
KESWINGTON MD-20895</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | | 23b. DATE
<i>12/5/1983</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Ft. Lincoln Cem.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Brentwood Pr. Geo. Md.</i> | | |
| 24. FUNERAL DIRECTOR NAME
<i>Valley's F.H. Inc.</i> | | | | | ADDRESS
<i>Mt. Rainier, Md.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 08 1983</i> | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Carver</i> | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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CONFIDENTIAL . . .

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

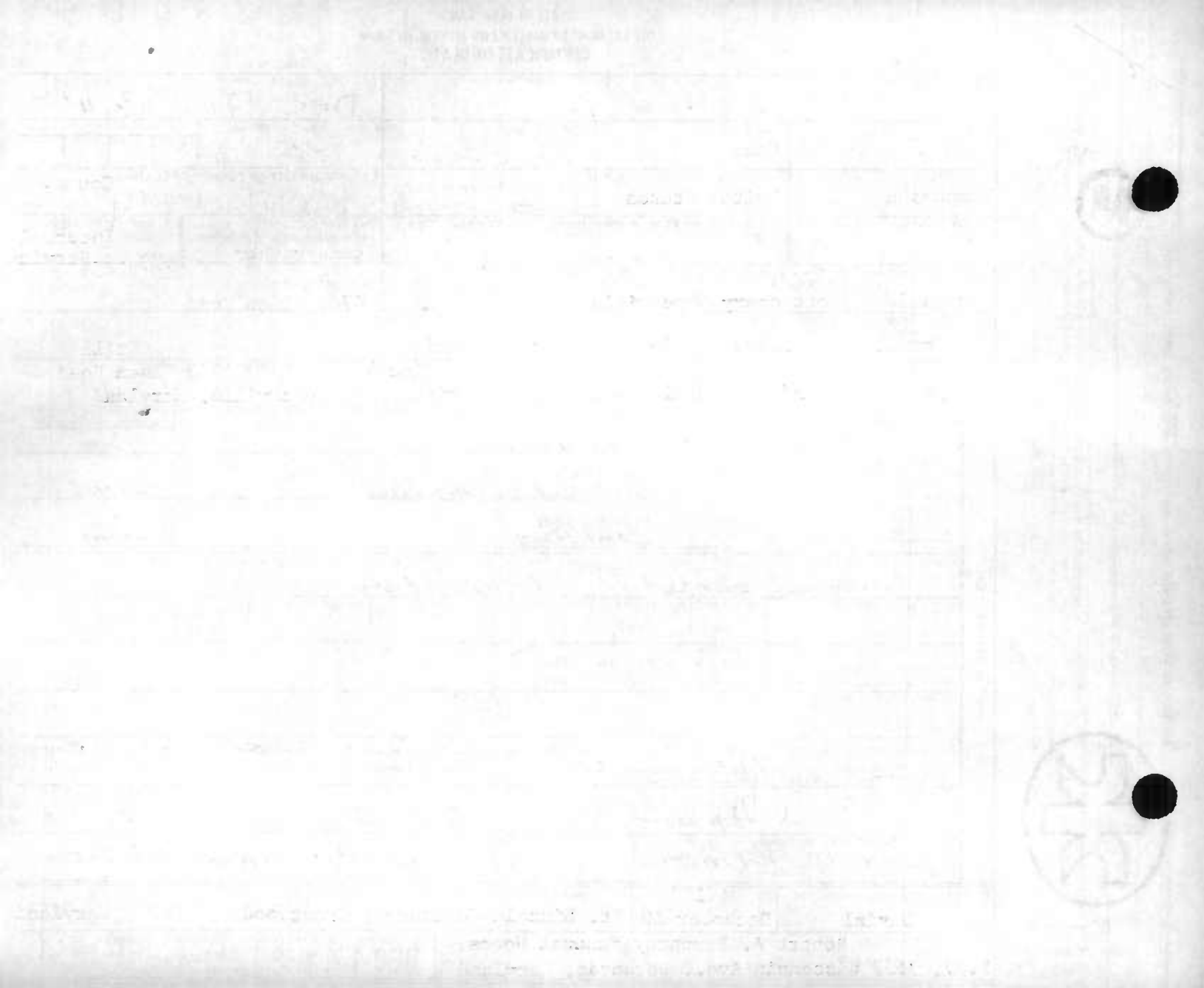
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Ethel B. Reed | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec 7, 1983 | | | 2b. HOUR
MIN.
11:40 PM | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
08 05 88 | | 6. AGE (IN YEARS LAST BIRTHDAY)
95 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Tennessee | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Stenographer | | 12b. KIND OF BUSINESS OR INDUSTRY
Revenue Service | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel Robert Copeland | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mattie Still | | 13e. STREET ADDRESS
4709 Olden Road | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
231-56-0785 | | 17. INFORMANT (Niece)
Ruth Crist | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4409
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Coronary artery disease
(c) Senile atrophy | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
16 hr
25 yrs
20 yrs | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Intestinal obstruction; dehydration | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 1983 to Dec 7, 1983 , that (I) (we) lost
saw the deceased alive on Dec 7, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (If (I) (we) did not view the body after death, so state.) | | | | | | | |
| 22b. SIGNATURE
John M. Humphrey | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/9/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John M. Humphrey | | 22e. ADDRESS
7801 Norfolk Ave Bethesda, MD 20814 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | | | ADDRESS
Funeral Homes, P.A., 7557 Wisconsin Ave., Bethesda, Maryland | | 25a. DATE REC'D. BY REGISTRAR
DEC 14 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. [Signature] | | | |

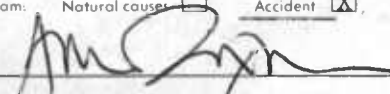

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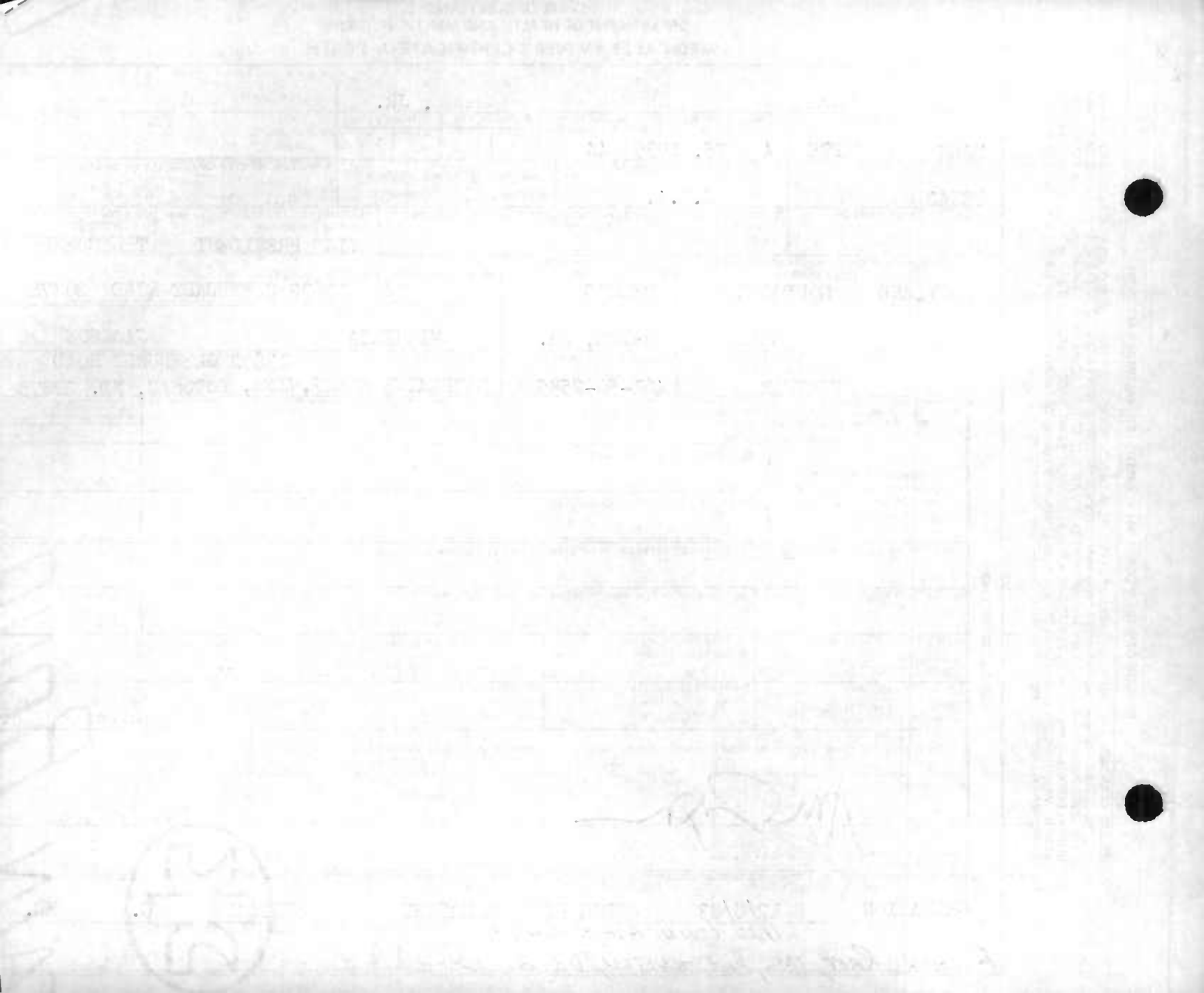


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

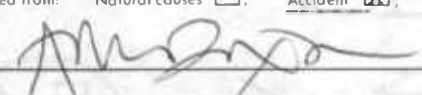
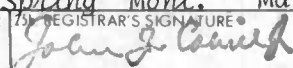
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|-------------------------------|--|---|--|--|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Thomas D. Reese, JR. | | | | | | 2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 12-6 1983 | | | | 2b. HOUR M | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR 4 25, 1939 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 44 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TEXAS | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 2c. DATE PRONOUNCED DEAD 12-6 1983 | |
| 7c. CITY OR TOWN OF DEATH Gaithersburg | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stoney Creek Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) VICE PRESIDENT | | 12b. KIND OF BUSINESS OR INDUSTRY TELECOMMUNIC. | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD. | | | | | | | | | | | |
| 10. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 11a. STATE MARYLAND | | 11b. COUNTY MONTGOMERY | | 11c. CITY OR TOWN POTOMAC | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 13632 GLENHURST ROAD 20878 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST THOMAS DEAL REESE, SR. | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST VIRGINIA JACKSON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) YES | | | | (IF YES, GIVE WAR OR DATES) VIETNAM | | 16b. SOCIAL SECURITY NO. 461-50-2585 | | 17. INFORMANT 13632 GLENHURST ROAD CATHARINE REESE, WIFE, POTOMAC, MD. 20878 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY: Multiple Injuries | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) 8/50
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | |
| (b) 8/50
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) 8/50
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR MONTH DAY YEAR 1:30 P.M. 12-6 1983 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto/fixed object impact | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE Stoney Creek Rd., Gaithersburg, Montgomery Co. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Md. | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) Assistant MEDICAL EXAMINER | | | | DATE SIGNED 12-7-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | | | 23b. DATE 12/8/83 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE SUITLAND PG. MD. | |
| 24. FUNERAL DIRECTOR NAME RICHARD RACE, INC., WASHINGTON, D.C. 20036 | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 14 1983 | | 25b. REGISTRAR'S SIGNATURE  | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Thomas L. Reiff | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 12/17/83 | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH Oct. 10 1961 | | 6. AGE (IN YEARS) 22 YRS. | | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | 2b. HOUR 1:30 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager Trainee | | 12b. KIND OF BUSINESS OR INDUSTRY Virginia Bnk | | | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4605 Brad Court | | 20853 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph S. Reiff | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jean Goss | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 219-54-9318 | | 17. INFORMANT ADDRESS Joseph S. Reiff Father Same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
8120 IMMEDIATE CAUSE (a) Cranio-cerebral trauma
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:30 PM 12/16/83 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subj. driver in auto/auto collision | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11820 Parklawn Dr. & Coakley, Rockville, Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 1219/83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Dec. 20, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md. | | | |
| 24. FUNERAL DIRECTOR NAME Francis J. Collins | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 23 1983 | | 25b. REGISTRAR'S SIGNATURE  | | | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | | | | | | | |

4

NO. 100-100000-100000

100-100000-100000

100-100000-100000

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|--|--|--|--|--|--|-------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
LEONARD | | | MIDDLE
- | | | LAST
RICKETTS | | | 2a. DATE OF DEATH
KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR | | | 2b. HOUR
M | | | | | |
| 3. SEX
Male | | | 4. RACE
White | | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 19 '36 | | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) YRS.
48 | | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12-21-83 | | | 7d. HOUR
6:01P | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Landscaping | | | 12b. KIND OF BUSINESS OR INDUSTRY
Parklawn Cem. | | | | | | | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Rockville | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
718 Schetland St. 20874 | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Herman Ricketts | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Gladys Irene Redmond | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- | | | 17. INFORMANT
ADDRESS
19317 Cedar Ct.
Robert Ricketts Germantown, Md. 20874 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Neck injury
8147
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
5PM P.M. 12-21-83 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
pedestrian struck by an auto | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
street | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Twinbrook Pkwy. & Halpine Street Rockville, Md. | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Margarita A. Korell, M.D. | | | | | | TITLE (SPECIFY)
M.D. Assistant | | | | | | MEDICAL EXAMINER | | | DATE SIGNED 12-22-83 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | | | ADDRESS 111 Penn Street | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Dec. 27, '83 | | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Montg. Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Gartner Sandison F.H. Gaithersburg, Md. 20878 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1983 | | | 25b. REGISTRAR'S SIGNATURE
John J. Gault | | | | | | | | | | | |



10-18-58

Walter R. Wells



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|--|---|---|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Ruth E. Rinker | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-28-83 | | | 2b. HOUR
4:05 AM | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 1, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Jackson Va. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Kensington | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Kensington Garden Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor/US Govt. State Dept. | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
DC. | | | 13b. COUNTY
131 | | 13c. CITY OR TOWN
Wash | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3000 McComas Av., Kensington, MD. 20895-1999 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Rinker | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ella Frye | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
577 60 7408 | | 17. INFORMANT
103 W. 3rd Street
Ethel T. Raymond Frederick, Maryland 21701 | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

7970

IMMEDIATE CAUSE (a) **Cardio-respiratory-failure**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Cachexia & Senility 5 years old Age

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | |
|------------------------------------|--|--|---|
| 19a. DATE OF OPERATION
— | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------------------|--|--|---|

| | | |
|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from **83**, 19 **60**, to **Dec 22**, 19 **83**, that (I) ~~was~~ lost
saw the deceased alive on **Dec 22**, 19 **83**, and that in (my) ~~own~~ opinion death occurred on the date and hour and from the causes stated
above, (I) ~~we~~ (I) ~~did~~ (I) ~~did not~~ view the body after death.

| | | |
|--|---|---------------------------------------|
| 22b. SIGNATURE
Allen J. McNeil MD | DEGREE | 22c. DATE SIGNED
12/28/1983 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Allen J. McNeil MD | 22e. ADDRESS
8601 Old Georgetown Rd Bethesda MD | |

| | | | |
|---|----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Jan. 3, 1984 | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Maryland |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY FUNERAL HOMES,
P.A., BETHESDA, MARYLAND | | 25a. DATE REC'D. BY REGISTRAR
JAN 9 1984 | 25b. REGISTRAR'S SIGNATURE
[Signature] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked with medical examiner, the medical examiner must be notified at once.

clear with medical examiner

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | | |
|---|--|--|--|---|---|--|--|--------------------------------|-----------------------------------|---|
| DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR A.M. | |
| Bertha | | | S. | | Riordan | Dec. 9 1983 | | | 5:45 M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| female | | caucasian | | Jan 28 1896 | | 87 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Penna. | | U.S. | | | | Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Bethesda | | | 5325 Mass. Ave. | | | housewife | | | home | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| 20816 Maryland | | | Montgomery | | Bethesda | | | 5325 Mass. Ave. 20816 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| Frank -- Schaffner | | | Bertha -- Demmien | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No --- | | | 578-62-3763 | | Loretta Escher, 106 Indian Rd., Toronto, Can. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4149</u> Coronary Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(b) Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 years
10 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Herpes Zoster | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>April 18, 1977</u> , to <u>Dec. 9, 1983</u> , that (I) (we) saw the deceased alive on <u>Dec. 8, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Maurice van Kinsbergen</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED <u>Dec. 9 1983</u> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Maurice van Kinsbergen, M.D.</u> | | | | | 22e. ADDRESS <u>5715 Mass. Ave. Bethesda Md. 20816</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 12/12/83 | | St. Boniface Cemetery | | Williamsport, Penna. | | | | |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisconsin Ave., NW, Washington, D.C. 20016</u> | | | | | 25. REC'D BY REGISTRAR <u>DEC 15 1983</u> | | 25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

cleaned by Med. Exam. Unit

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Abraham Ritzenberg | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 12, 1983 | | | 2b. HOUR
12 59 P.M. | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
04 15 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 Years old | | 7. UNDER 1 YEAR MONTHS DAYS
8. UNDER 74 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MERCHANT | | 12b. KIND OF BUSINESS OR INDUSTRY
SCRAP METAL | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1104 TIFFANY ROAD 20904 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
SAMUEL RITZENBERG | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
SADIE KAPLAN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
NO (IF YES, GIVE WAR OR DATES) | | | 16b. SOCIAL SECURITY NO.
579-12-9029A | | 17. INFORMANT ADDRESS
EDITH RITZENBERG, 1104 TIFFANY ROAD, SILVER SPRING, MARYLAND | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) Cardiac arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF } (c) Hypertensive arteriosclerotic heart disease
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. Diabetes | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from November 19 74, to 12-6 19 83, that (I) (we) last saw the deceased alive on 12-6 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-6-83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
VASON GELDER, M.D. | | | 22e. ADDRESS
8830 CAMERON STREET
SILVER SPRING, MD. 20910 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | | 23b. DATE
12/7/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
KING DAVID MEMORIAL GARDEN | | 23d. LOCATION
CITY OR TOWN
FALLS CHURCH, VIRGINIA | | | |
| 24. FUNERAL DIRECTOR
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D.C. | | | | | | | | | | |
| 16c. DATE REC'D BY REGISTRAR 17. REGISTRAR'S SIGNATURE
DEC 12 1983 [Signature] | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with (in 72 hours after death) with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|---|--|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOHN ACHESON ROBERTSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 20 1983 | | 2b. HOUR
4:30 P_M | |
| 3. SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 26 1935 | | 6. AGE (IN YEARS LAST BIRTHDAY)
48 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MASSACHUSETTS | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
U. S. NAVY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
ST. MARY'S | 13c. CITY OR TOWN
LEXINGTON PK | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
GEAST RENNELL 20653 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRANK ROBERTSON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
TRESSA ACHESON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1955-1976 | | 17. INFORMANT
ADDRESS
MARY E. ROBERTSON, RFD #1, BOX 197, EPPING, NH | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INTERCRANIAL BLEED
4329
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 14 1983 to DECEMBER 20 1983 , that (I) (we) last saw the deceased alive on DECEMBER 20 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<i>E. Killeavy</i> | | | | DEGREE
MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
21 Dec 83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
E. KILLEAVY, LT, MC, USNR | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 24, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Brentwood Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood New Hampshire |
| 24. FUNERAL DIRECTOR
NAME
Brewitt Funeral Home
14 Pine Street Exeter, New Hampshire | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1983
25b. REGISTRAR'S SIGNATURE
<i>John J. Connel</i> | | |

BP _____

and several others

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR 15 ME (3))
15M2/80

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|------------------|--|---|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Josephine Marian Robinson | | | | | | | | | | 2a. DATE KNOWN OF DEATH Dec 25 1983 | |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH June 10 1911 | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | 7. IF UNDER 1 YR. MONTHS DAYS | 8. IF UNDER 24 HRS. HOURS MIN | 2c. DATE PRONOUNCED DEAD Dec 25 1983 | | 2b. HOUR 4:45 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH S. L. Spg | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY Medical | | | |
| 13a. STATE MD | | 13b. COUNTY Mont | | 13c. CITY OR TOWN S. L. Spg | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 29910 1220 East-West Highway | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Russell | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Evans | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 577-56-3674 | | | 17. INFORMANT ADDRESS Bessie Cornelius, 1220 East-West Highway, Silver Spring, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
4291
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 None | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers | | | TITLE (SPECIFY) Dep | | | MEDICAL EXAMINER | | | DATE SIGNED Dec 25 1983 | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers | | | ADDRESS 1919 Seminary Rd., Silver Spring, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 12/29/83 | | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Prince Georges, Md. | | | |
| 24. FUNERAL DIRECTOR NAME McGuire Funeral Service, 7400 Georgia Ave. N.W. | | | ADDRESS Washington, D.C. | | | 25a. DATE REC'D. BY REGISTRAR JAN 03 1984 | | 25b. REGISTRAR'S SIGNATURE John J. Canick | | | |

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|--|--|----------|-----------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | FIRST MIDDLE LAST | | | | | DECEMBER 14 1983 | | | 12:15 PM | | |
| JULIA MULLIS ROOD | | | | | | | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| FEMALE | | | CAUCASIAN | | | OCTOBER 24 1917 | | | 66 YRS. | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| GEORGIA | | | UNITED STATES | | | | | | MONTGOMERY MD. | | | | | | |
| 7c. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BETHESDA | | | NAVAL HOSPITAL | | | | | | SCHOOL TEACHER | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6415 EPPARD STREET | | 99999 | | |
| VIRGINIA | | | FAIRFAX | | | FALLS CHURCH | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | |
| JAMES ARTHUR MULLIS | | | | | LULA BELLE PHILLIPS | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | | | | | |
| NO | | | - | | | 578-28-5781 | | | | SALLY A. ROOD, 3115 MARTHA CUSTIS DRIVE, | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | ALEXANDRIA, VA 22302 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <u>1749</u> <u>WIDELY METASTATIC CARCINOMA OF THE BREAST</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | | | |
| | | | P.M. 19 | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 12</u> , 19 <u>83</u> , to <u>DECEMBER 14</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>DECEMBER 14</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | | | | 22c. DATE SIGNED | | | | | | |
| <u>Victor A. Aletich</u> | | | <u>MD</u> | | | | | | <u>15 DEC 83</u> | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | | | | |
| VICTOR A. ALETICH, LCDR, MC, USNR | | | NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | |
| Burial | | | Dec 19, 1983 | | | Edgewater Cemetery; | | | Edgewater, Florida | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | 25. DATE REC'D BY REGISTRAR | | | 25. REGISTRAR SIGNATURE | | | | | | | | | |
| Colonial Funeral Home; Falls Church Virginia | | | DEC 21 1983 | | | <u>John J. Baker</u> | | | | | | | | | |

19 FEB 1963

100-100000

X REC 23

Value 14.56

100-100000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

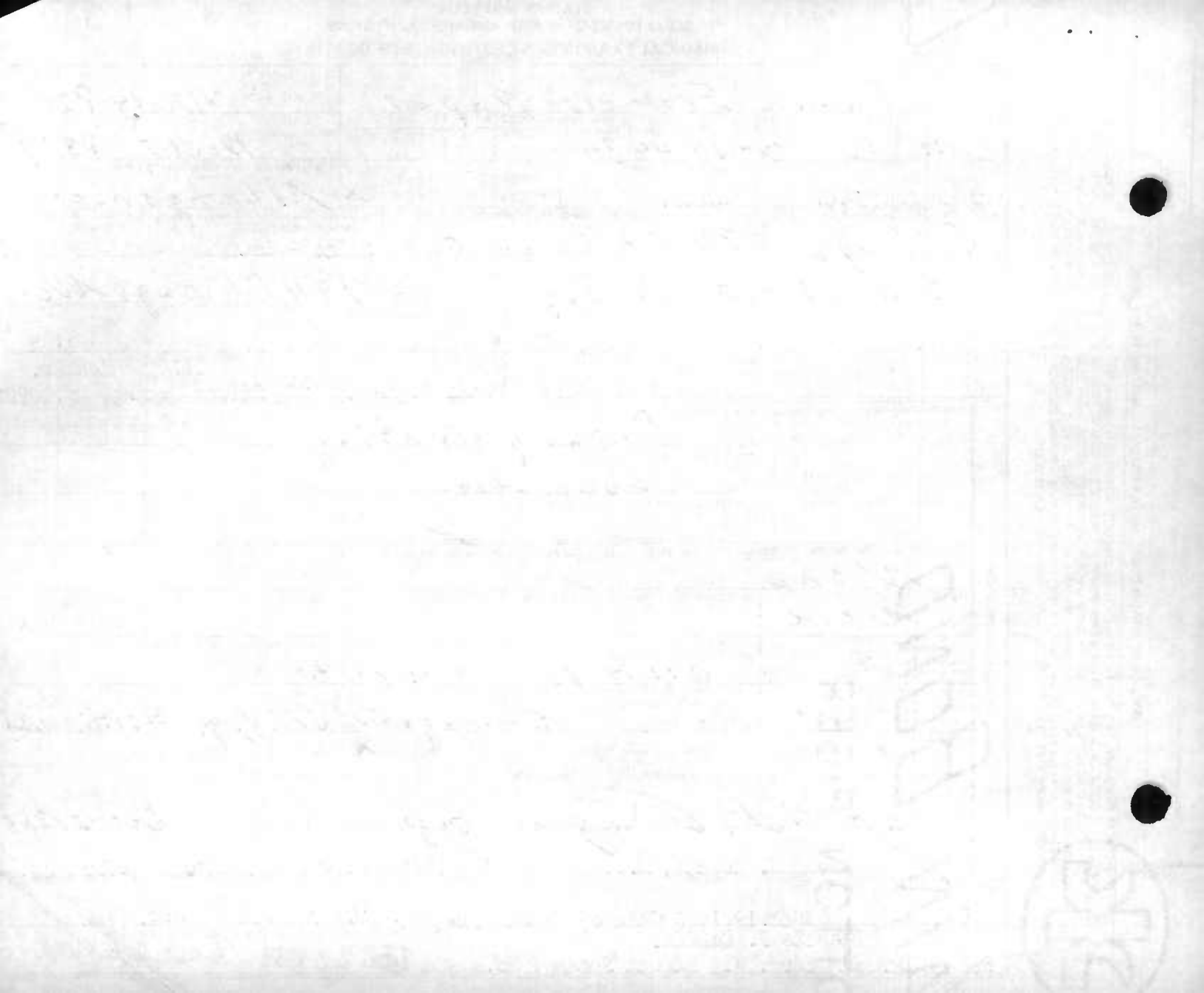
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

33811

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | |
|---|---------------------|--|--|---|--|--|--|---|-------------------------|-------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Edwin Francis Roper | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED Dec 19 1983 | | | | 2b. HOUR
8 P. | |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR Oct 14 49 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 34 YRS. | 7. UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
Dec 15 1983 | | 7d. HOUR
8 P. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Pt. L. Spg. | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
794 Chicago Ave | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales - Cars | | 12b. KIND OF BUSINESS OR INDUSTRY
Self-Employed | | | |
| 13a. STATE
MD | | 13b. COUNTY
Mont | | 13c. CITY OR TOWN
Pt. L. Spg. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
794 Chicago Ave. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edwin A. Roper, III | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Doris S. Sponsler | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
219-54-8054 | | 17. INFORMANT
Doris S. Roper | | ADDRESS
2110 Dayton St. Silver Spring, Md. 20901 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 9560 Enanguination
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b) Excitation
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
12 14 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Cut wrists | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Chicago Ave Pt. L. Spg. Mont. MD | | | | | |
| 22. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
John S. Rogers | | | | TITLE (SPECIFY)
M.D. | | | | MEDICAL EXAMINER | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
John S. Rogers, M.D. | | | | ADDRESS
1919 Seminary Rd. Silver Spring, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec 19 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Mont. Md. | | | | |
| 24. FUNERAL DIRECTOR NAME
Francis J. Collins | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 23 1983 | | | 25b. REGISTRAR'S SIGNATURE
John J. Gair | | | | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ROSE | | | 2a. DATE OF DEATH MONTH DAY YEAR
DEC 25 1983 | | | 2b. HOUR
4:00p.m. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 6 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
St. Louis, Missouri | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD. | |
| 10. CITY OR TOWN OF DEATH
KENSINGTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4302 Colchester Drive | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary (Ret.) | |
| 13a. STATE
MD. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Kensington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Solomon FEIDMAN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
IDA FEIDMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
Photographic | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
398 320848 | | 17. INFORMANT
ADDRESS
Son | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1749

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **breast cancer**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**5 min****all 2 x rx**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Smoking

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/26 , 19 83 , to 12/25 , 19 83 , that (I) (we) lost
saw the deceased alive on 12/18 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Edward H. Seidman | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/25/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EDWARD H. LEVIAL | | 22e. ADDRESS
8630 PENTON ST / FORT G. GARD | | | | | |

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/27/83 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Gdn. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church, Fairfax, Virginia | |
| 24. FUNERAL DIRECTOR
NAME
DANZANSKY-GOLDBERG MEMORIAL CHAPEL | | ADDRESS
1170 Rockville Pike; Rockville, Md. 20852 | | 25a. DATE REC'D. BY REGISTRAR
DEC 28 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be
returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in case

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|---|---|---|--|--|---|--|-------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Irene B Rounds | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 1 1983 | | | 2b. HOUR
11:45 AM | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 6 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery city MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Collingswood | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Receptionist | | 12b. KIND OF BUSINESS OR INDUSTRY
C.I.A. | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Bower | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julia Skelly | | | 13a. STREET ADDRESS
4998 Battery Lane # 403 | | | 20814 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | 16b. SOCIAL SECURITY NO.
579-40-7097 | | 17. INFORMANT
Son
Arthur B. Rounds | | ADDRESS
9819 Singleton Dr.
Bethesda, Md. 20817 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RESPIRATORY ARREST

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

10 MINUTES

5150
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) BRONCHOPNEUMONIA

2 WEEKS

DUE TO, OR AS A CONSEQUENCE OF

(c) PULMONARY FIBROSIS AND EMPHYSEMA

30 YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

ANGINA PECTORIS; SQUAMOUS CELL CARCINOMA OF PHARYNX

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☒YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

22a. I certify that (I) (this hospital) attended the deceased from OCT. 4, 19 83, to DEC. 1, 19 83, that (I) ~~lost~~ saw the deceased alive on NOV. 30, 19 83, and that in (my) ~~own~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~will~~ did view the body after death.

22b. SIGNATURE
Joseph Connor

DEGREE

MD

ATTENDING
PHYSICIANMEDICAL
DIRECTORSTAFF
PHYSICIAN

22c. DATE SIGNED

Dec. 1, 1983

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Joseph Connor

22e. ADDRESS

4420 Old Georgetown Rd. Bethesda, MD

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

Dec. 5, 1983

23c. NAME OF CEMETERY OR CREMATORY

Arlington National

23d. LOCATION
CITY OR TOWN COUNTY STATE

Arlington

Virginia

24. FUNERAL DIRECTOR Francis J. Collins

500 University Blvd., W. Silver Spring, Md.

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DEC 6 1983

John J. Conner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 4, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
BESSIE L. ROYCE | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 29 83 | | 2b. HOUR
A M
2 15 | |
| 3. SEX
Female | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
5 23 08 | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
SS. | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
3524 Peartree Court #9 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Eugene Francis Baker | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Follin | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
UNKNOWN | | 16b. SOCIAL SECURITY NO.
212-10-0539 | | 17. INFORMANT
ADDRESS
8224 Hawkins Creamery Rd
Gaithersburg, Md. | |

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).

PART 1: DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF

2503
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DIABETIC NEPHROPATHY

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

GASTRITIS

| | | | | | |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 60 to 12-29 19 83, that (I) (we) last saw the deceased alive on 12-29 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
M Snow MD | | DEGREE | | 22c. DATE SIGNED
12-29-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Margaret T. Snow, M.C. | | 22e. ADDRESS
9013 Flower Avenue Silver Spring, Md. | | | |

| | | | |
|---|---------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
Jan. 2, 1984 | 23c. NAME OF CEMETERY OR CREMATORY
National Memorial Park | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church Fairfax Virginia |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Francis J. Collins
500 University Blvd., W. Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
JAN 6 1984 | 25b. REGISTRAR'S SIGNATURE
John J. Conner |

BP

Handwritten text, mostly illegible due to fading. Some words like "family" and "children" are faintly visible.



Handwritten text, mostly illegible due to fading. Some words like "X" and "children" are faintly visible.



Handwritten text, mostly illegible due to fading. Some words like "children" and "X" are faintly visible.



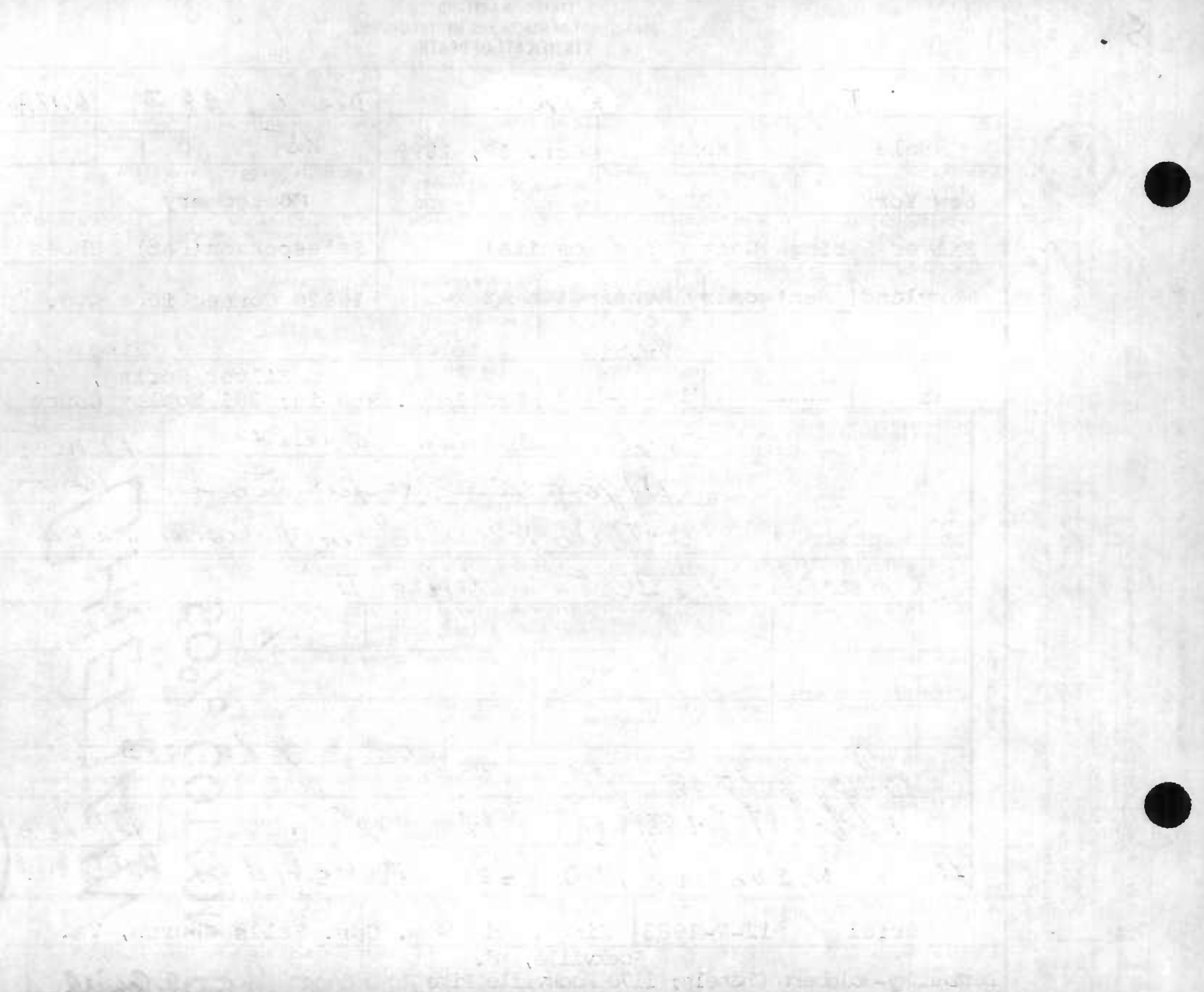
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|---|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| JACK RUBBIN. | | | Dec. 6, 1983 | | | 6:17A | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | |
| Male | White | Oct. 19, 1898 | 85 YRS. | | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| New York | USA | | Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Silver Spring | Holy Cross Hospital | | Salesperson (Ret) | | | Shoes | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | |
| Maryland | | | Montgomery | | | Kensington | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. SOCIAL SECURITY NO. | | |
| ISAAC Rubbin | | | Zelda Fine | | | 106-10-1683 | | |
| 17. INFORMANT | | | 18. CAUSE OF DEATH | | | | | |
| Ronald S. Rubbin; 301 Notley Court | | | PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>diabetes Mellitus type II</u> | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/2/83 to 12/6/83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | 22b. SIGNATURE
Morton W. Shapiro, M.D. | | | 22c. DATE SIGNED
12/6/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | |
| Morton W. Shapiro, M.D. | | | 5225 Pooks H. II Rd. Beth Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | |
| Burial | | | 12-7-1983 | | | King David Mem. Gdn. Falls Church, Va. | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | DEC 9 1983 | | | John J. Carver | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

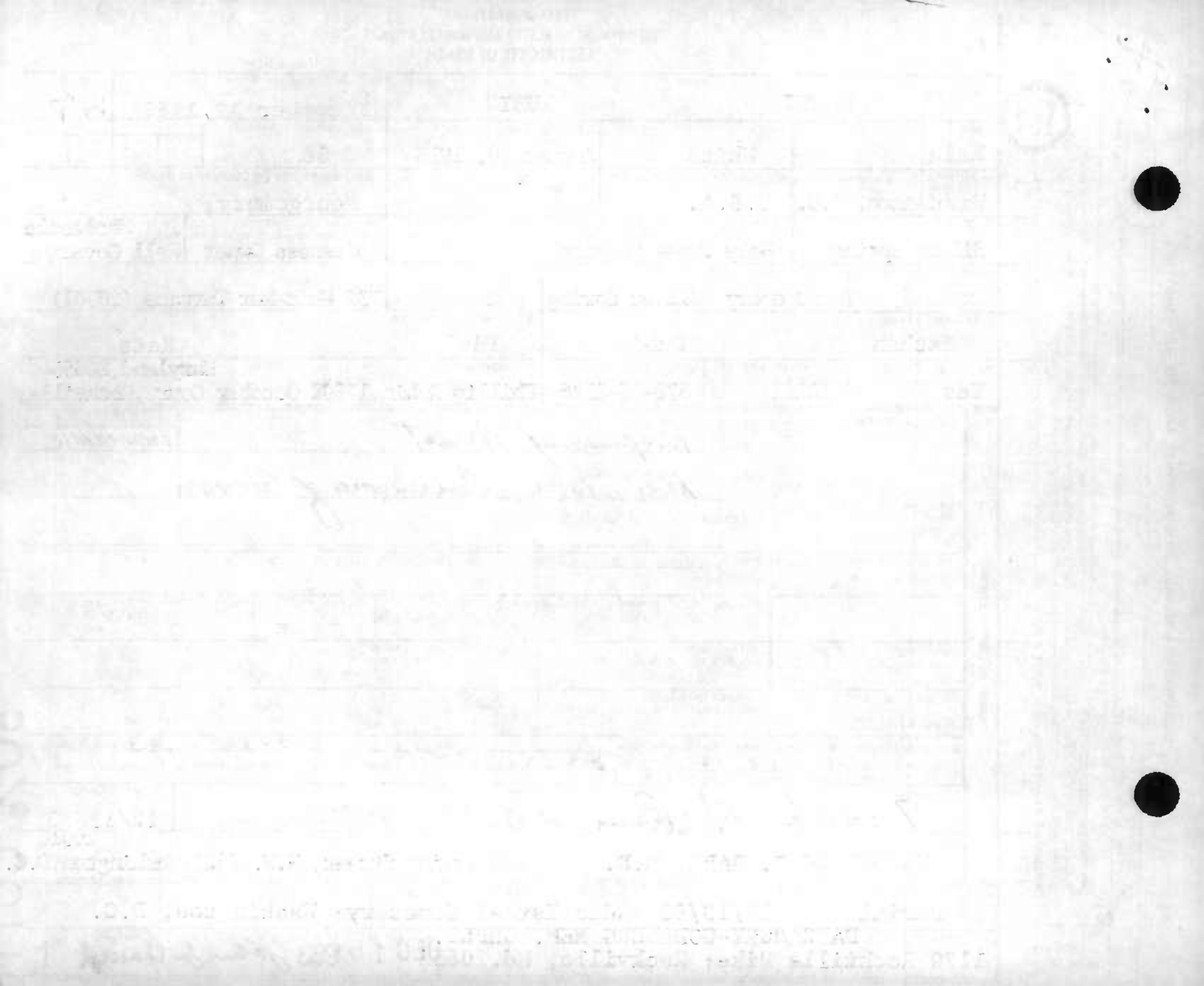
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpages, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HENRY RUBIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 12, 1983 | | 2b. HOUR
12:12 PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
August 29, 1915 | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery, MD. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Business Owner | 12b. KIND OF BUSINESS OR INDUSTRY
Wholesale Wall Covering | | |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
732 Whitaker Terrace (20901) | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Nathan Rubin | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Katz | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WWII | | 16b. SOCIAL SECURITY NO.
578-05-8526 | | 17. INFORMANT
ADDRESS
Maryland 20855
Phillip Rubin; 17808 October Court; Rockville, | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
1519
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Mezenteric Circulation of Stomach</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Immediate</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>12-12</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Frederick G. Barr M.D.</u> | | DEGREE
M.D. | | 22c. DATE SIGNED
12/12/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
FREDERICK G. BARR, M.D. | | 22e. ADDRESS
106 Irving Street, N.W., #421; Washington, D.C. 20010 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPEC)
Burial | 23b. DATE
12/13/83 | 23c. NAME OF CEMETERY OR CREMATORY
Adas Israel Cemetery; Washington, D.C. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR DANZANSKY-GODLBERG MEM. CHPLS
1170 Rockville Pike; Rockville, Md. 20852
DATE REC'D. BY REGISTRAR 15 1983 REGISTRAR'S SIGNATURE <u>John J. Gough</u> | | | | | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5, FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

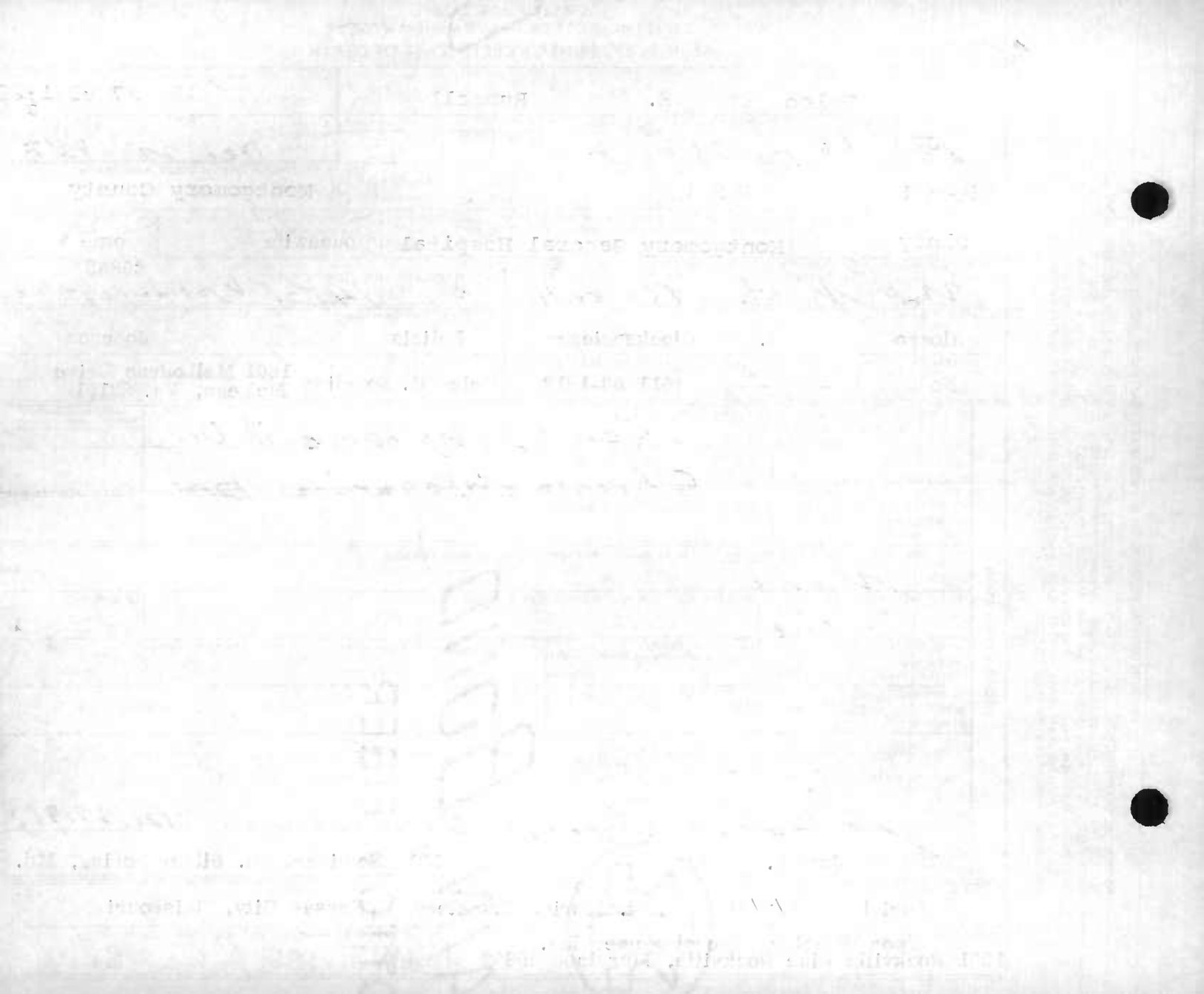
BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|---------------------|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Helen E. Russell | | | | 2a. DATE KNOWN OF DEATH
MONTH <input checked="" type="checkbox"/> 12 DAY 27 YEAR 83 | | | | 2b. HOUR
1:26
a M | |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec 28 01 81 | 6. AGE (IN YEARS)
LAST BIRTHDAY
81 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
Dec 27 19 83 | | 2d. HOUR
1:26
a M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Missouri | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
MD | | | | 13b. CITY OR TOWN
Rockville | | 13c. STREET ADDRESS
14535 Woodcrest Rd | | 20853 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Alonzo A. Glockengieser | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Felicia Johnson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
511-68-1812 | | 17. INFORMANT
ADDRESS
Helen E. Sparling 1801 Melbourne Drive
McLean, Va. 22101 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden Myocardial Dis.
4291
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
None | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE
John S. Rogers | | | | TITLE (SPECIFY)
M.D. Boys MEDICAL EXAMINER | | | | DATE SIGNED
Dec 27 1983 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
John S. Rogers | | | | ADDRESS
1919 Seminary Rd. Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
1/3/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Moriah Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Kansas City, Missouri | | |
| 24. FUNERAL DIRECTOR
NAME
Tyson Wheeler Funeral Home, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 3 1984 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | |
| 1331 Rockville Pike Rockville, Maryland 20852 | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Nan W. Rust | | | | 2a. DATE OF DEATH
MONTH December DAY 18 YEAR 1983 | | | | 2b. HOUR
12:15pm | | | |
| SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH June DAY 22 YEAR 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Delaware | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Fernwood House | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS
20817 6530 Democracy Blvd. | | | | | | | |
| 14. FATHER'S NAME
FIRST Edward MIDDLE W. LAST Russell | | | | 15. MOTHER'S MAIDEN NAME
FIRST Mary MIDDLE E. LAST Fisher | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
221 10 3576 | | 17. INFORMANT grand daughter Rockville, MD
Nancy Wheeler 14523 Parkvale Road | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4140
IMMEDIATE CAUSE (a) Cardio Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c) Personal knowledge
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 months | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from 9/9 , 19 83 , to 12/18 , 19 83 , that (I) was lost saw the deceased alive on 12/19 , 19 83 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, so state.) | | | | | | | | | | | |
| 22b. SIGNATURE
J. Blaine Fitzgerald, M.D. | | | | DEGREE M.D.
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/19/83. | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. Blaine Fitzgerald, M.D. | | | | 22e. ADDRESS
8218 Wisconsin Ave. Bethesda. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | | 23b. DATE
Dec 22, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Johnstown Cem. | | 23d. LOCATION
CITY OR TOWN Greenwood COUNTY Delaware STATE | | | |
| 24. FUNERAL DIRECTOR
NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1983 | | | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | |

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Mahlon B. Saffell | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 10 83 | | 2b. HOUR
1315 ^P _M |
| 3. SEX
MALE | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
2 6 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63
YRS | |
| 7. BIRTHPLACE
(STATE OR FOREIGN CTRY)
Md | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Painter | | 12b. KIND OF BUSINESS OR INDUSTRY
House |
| 13a. STATE
Md | 13b. COUNTY
Carroll | 13c. CITY OR TOWN
Westminster | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
421 Springdale Rd 21157 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Howard Saffell | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Genevieve | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, GIVE BRANCH) (IF YES, GIVE WAR OR DATES)
NO NONE | |
| 16b. SOCIAL SECURITY NO.
212-209709 | | 17. INFORMANT
Frita Petry | | ADDRESS
13e 21157 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
4920
DUE TO, OR AS A CONSEQUENCE OF
(b) Emphysema
DUE TO, OR AS A CONSEQUENCE OF
(c)
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hours.
10 yrs. |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (his hospital) attended the deceased from 12/9/83, 19, to 12/10, 1983, that (I) (we) last saw the deceased alive on 12/10, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Carl I. Schoenberger MD. | | DEGREE
MD. | | 22c. DATE SIGNED
12/11/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Carl I. Schoenberger | | 22e. ADDRESS
4701 Randolph Rd Rockville MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE)
Burial | | 23b. DATE
12-12-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Uniontown | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Westminster Carroll Md. | | 23e. NAME OF REGISTRAR
Robert Kyle Britts Jr. Westminster, Md. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



RELEASED BY DR. MAYLE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/76
(VR A 15 (4))STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) Ralph F. Salmon | | MONTH DAY YEAR
December 28, 1983 | | 12:26 ^{pm} | |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
May 14, 1921 | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Gov't Employee | | 12b. KIND OF BUSINESS OR INDUSTRY
HEW, US Government |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Rockville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Reuben Salmon | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence Steele | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW II 178-14-1200 | | 17. INFORMANT ADDRESS
Sarah E. Salmon, same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Peritonitis
DUE TO, OR AS A CONSEQUENCE OF (b) Rupture of Lower Esophagus
DUE TO, OR AS A CONSEQUENCE OF (c) Excessive Wretching From Meat In Esophagus
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 Days
10 Days | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Chronic Smoker and Excessive Alcohol Intake | | | | | |
| 19a. DATE OF OPERATION
12/18/1983 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Rupture of Esophagus | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 18, 1983 to Dec. 28, 1983 , that (I) (we) last saw the deceased alive on December 28, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (us) (do not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>L. Alberto Nunez</i> | | DEGREE
MD | | 22c. DATE SIGNED
Dec. 28, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
L. Alberto Nunez, MD | | 22e. ADDRESS
8218 Wisconsin Avenue, Bethesda, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
Dec. 30, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | |
| 23d. LOCATION (CITY OR TOWN)
Alexandria, Virginia | | 23e. STATE
VA | | | |
| 24. FUNERAL DIRECTOR NAME
ROBERT A. PUMPHREY | | 24b. ADDRESS
FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND | | 25a. DATE REC'D. BY REGISTRAR
JAN 3 1984 | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>Joan J. Carver</i> | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B follows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|--|---|--|---|--|--|---|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Alfred P. SALYER | | | 2a DATE OF DEATH
MONTH DAY YEAR
Dec. 6, 1983 | | | 2b HOUR
6 29
P.M. | | | | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
MONTH DAY YEAR
Sept 23 1886 | | 6 AGE (IN YEARS LAST BIRTHDAY)
97
YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | |
| 10 CITY OR TOWN OF DEATH
Kensington | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
10010 Wildwood Rd. | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Accountant | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a STATE
Maryland | | | 13b COUNTY
Montgomery | | 13c CITY OR TOWN
Kensington | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
10010 Wildwood Rd. 20895 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Edward Salyer | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Herdman | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b SOCIAL SECURITY NO.
189-03-5586 | | 17 INFORMANT
ADDRESS
Marjorie Saunders, Item 13 | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
4140
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Coronary arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 mms
10 years | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from June 12, 1981 to Dec 6, 1983 , that (I) (we) last saw the deceased alive on Dec 4, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE
John F. Tauber | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED
12-6-83 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
John Tauber | | | | | 22e ADDRESS
8218 Wisconsin Ave. Bethesda Md. | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b DATE
Dec. 9, 1983 | | 23c NAME OF CEMETERY OR CREMATORY
Woodlawn | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Dallas, Luzerne, Pa. | | | |
| 24 FUNERAL DIRECTOR
NAME
Clint L. Molesworth, P.A., Damascus, Md. | | | | | 25a DATE REC'D. BY REGISTRAR
DEC 14 1983 | | | | | |
| | | | | | 25b REGISTRAR'S SIGNATURE
John J. Connel | | | | | |

BP

CONFIDENTIAL

SECRET

CONFIDENTIAL

SECRET

CONFIDENTIAL

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CONFIDENTIAL

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HYACINTH I. SANMOOGAN | | | 2a. DATE OF DEATH MONTH DAY YEAR
December 1, 1983 | | | 2b. HOUR
7:45 AM | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 26, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
7 4 5 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Guyana | | 7b. CITIZEN OF WHAT COUNTRY?
Guyana | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION
(IF NOT INSURE CITY, GIVE STREET ADDRESS)
Housewife | | 12b. KIND OF BUSINESS OR
INDUSTRY
Own Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Prince Geo. | | 13c. CITY OR TOWN
Largo | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10907 Layton Street 20772 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown Giles | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence Johnson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
076 66 5696 | | 17. INFORMANT
Samuel W. Alleyne
10907 Layton Street
Largo, Md. 20772 | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

0128

IMMEDIATE CAUSE (a) **Tuberculosis of mediastinum + spine**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

unknown

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

Congestive Heart Failure, Candidiasis

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION
10-16-83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Bopsy Spine mass | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 19 83 , to 12-1 19 83 , that (I) (we) lost
saw the deceased alive on 11-30 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Francis Gasch | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12-1-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
F. Cantor | | | | 22e. ADDRESS
6545 Belcrest Rd Hyattsville | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/7/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Mem. Park Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Landover P.G. Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Francis Gasch's Sons Funeral Home, P.A.
Hyattsville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 9 1983 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. Canine | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|---------------------------------------|---|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | MONTH DAY YEAR | | 2b. HOUR | |
| Ruby Lee Saris | | December 27, 1983 | | 2:00P M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Female | Caucasian | MONTH DAY YEAR | 59 YRS. | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| North Carolina | United States | | Montgomery County MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | 10643 Weymouth Street | Vice-President | Construction | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Maryland | Montgomery | Bethesda | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | zip 20814
10643 Weymouth St., #101 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | |
| Francis | Helen | No | | | |
| 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS | | | |
| 579 20 3744 | James N. Saris (husband) | see #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Standstill</u>
4148
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Severe Congestive heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Ischemic Cardiomyopathy</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>6 minutes</u>
<u>2 years</u>
<u>2 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Insulin-dependent diabetes Mellitus</u> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>February 27, 1981</u> to <u>December 27, 1983</u> , that (II) (we) lost
saw the deceased alive on <u>December 14, 1983</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated
above (II) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>James E. Wilson, M.D.</u> | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/28/83</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | | | |
| James E. Wilson, MD | 11125 Rockville Pike, Rockville, Md. 20852 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| Burial/Transit | Dec. 30, 1983 | Mt. Zion Cemetery | Skyland, North Carolina | | |
| 24. FUNERAL DIRECTOR
NAME | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | |
| Robert A. Pumphrey, Funeral Homes,
P.A. Bethesda, Maryland | | | JAN 3 1984 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Connel</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Chester Sartwell | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 29 1983 | | 2b. HOUR
8:00 AM |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
May 12, 1903 | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
20 12 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Michigan | 7b. CITIZEN OF WHAT COUNTRY?
USA. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6702 Westmoreland Avenue | | 12a. USUAL OCCUPATION
(TYPE OF MOST OF WORKING LIFE)
Farmer | | 12b. KIND OF BUSINESS OR
Agriculture |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. CITY OR TOWN
Takoma Park | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Fred Sartwell | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ruth Eagle | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
380322396 | 17. INFORMANT
ADDRESS
James Sartwell-1196 Hillcrest Rd, Odenton, MD | | |
| CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
4275 DUE TO, OR AS A CONSEQUENCE OF
(b) ADVANCED CARDIOPULMONARY DISEASE 5 yrs
DUE TO, OR AS A CONSEQUENCE OF
(c) ADVANCED CIRRHOSIS OF LIVER | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 DAY |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ADVANCED CIRRHOSIS OF LIVER | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (his hospital) attended the deceased from Aug. 31 1981 to 11/30 1983 , that (I) (we) last saw the deceased alive on 11/30 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Bruno Koleca, MD | | | | 22c. DATE SIGNED
12/29/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BRUNO KOLECA, MD | | | | 22e. ADDRESS
4400 SADDLE RD. DEALEE TOWNSHIP 20074 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Dec 31 1983 | 23c. NAME OF CEMETERY OR CREMATORY
Lakeview Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY
Howell, Michigan | |
| 24. FUNERAL DIRECTOR
NAME
Ives-Pearson F. H. Arlington, Va. 22201 | | | 25a. DATE REC'D. BY REGISTRAR
JAN 03 1984 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
John J. Carr | | |

BP



100

RECEIVED FEB 19 1964

100

100

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Albert Schneider | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 30 1983 | | | 2b. HOUR
3:00 PM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 14, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4450 S. Park Avenue #404 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Reporter | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Congress | |
| 13a. STATE
Md. | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Morris Schneider | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Levine | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | |
| 16b. SOCIAL SECURITY NO.
577-64-4756 | | | 17. INFORMANT ADDRESS
Martha B. Schneider 4450 S. Park Ave. Chevy Chase Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma Of Prostate
1850
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. {
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 Years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Cerebro Vascular Disease, Ischemic Heart Disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 19 82 , to Dec. 30 19 83 , that (I) (we) lost saw the deceased alive on Dec. 30 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Neil A. Crane, MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/30/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Neil Allan Crane M. D. | | | | | | 22e. ADDRESS
5480 Wisc. Ave. Chevy Chase, Md. 20815 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Cremation | | | 23b. DATE
12/31/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION
Suitland Montgomery Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph Gawler's Sons Inc. | | | | | | 5130 Wisc. Ave. N.W.
Washington, D.C. | | DATE REC'D. BY REGISTRAR
JAN 5 1984 | |
| 25b. REGISTRAR'S SIGNATURE
John J. Lankford | | | | | | | | | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|------------------|--|--|---|-----------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Joseph - Schneider | | | 2a. DATE OF DEATH MONTH DAY YEAR
12 14 83 | | 2b. HOUR
2:40 P.M. |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 15 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
HUNGARY | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
OLNEY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BROOKE GROVE NURSING HOME | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CUSTODIAN | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | 13b. COUNTY
MONT. | | 13c. CITY OR TOWN
SILVER SPRING | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
SCHEIDER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
214 46 6688 | | 17. INFORMANT
ADDRESS
ANNA SCHNEIDER - 1443 HARDING LANE | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory failure
4149
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Congestive Heart failure
(c) Atherosclerosis (CAD) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
36 hrs
6 mo.
years |
|---|--|--|

| | | | |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.
Chronic Renal Failure; Anemia | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/14/83 to 12/14/83, that (I) (we) lost saw the deceased alive on 12/14/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body (after) death. | | | |
| 22b. SIGNATURE
D. H. Ligon MD | | DEGREE
MD | 22c. DATESIGNED
12/14/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
D. H. Ligon MD | | 22e. ADDRESS
1811 P+Philly Dr., Olney MD 20832 | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | 23b. DATE
Dec 19, 1983 | 23c. NAME OF CEMETERY OR CREMATORY
Northock Mem Park | 23d. LOCATION
NOROCK MOUNT MD |
| 24. FUNERAL DIRECTOR
NAME
Tobias Funeral Home 204 Canal St., N. Wash. D.C. | | 25. DATE REC'D. BY REGISTRAR
19 1983 | |
| 26. REGISTRAR'S SIGNATURE
J. E. C. ... | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1911
May 15
Chicago
Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the Chicago and North Western Railway Company.
The same has been forwarded to the proper authorities for their consideration.
Very respectfully,
J. H. [Name]
[Title]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
KARL SCHNURNBERGER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-20-83 | | | 2b. HOUR
3:00 P | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
JUNE 21 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN.
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
GERMANY | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
GAITHERSBURG | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
101 ODEN HALL RD. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RET- BLDG. ENG. | | 12b. KIND OF BUSINESS OR INDUSTRY
APARTMENTS | |
| 13a. STATE
MD | | | 13b. COUNTY
MONTG. | | 13c. CITY OR TOWN
GAITH' BURG | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE
101 ODEN HALL RD. 20877 | | | 14. FATHER'S NAME
FIRST MIDDLE LAST
CHRISTIAN SCHNURNBERGER | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA FLAD | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
067-14-6883 | | 17. INFORMANT
ADDRESS
MRS. SUZANNE BAR-OR 20009 HOB HILL GAITHERSBURG MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
1579
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma of Pancreas
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1/2 HOUR
1 YEAR |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-15-76 , 19____, to 12-20 , 19 83 , that (we) lost saw the deceased alive on 12/20 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Norman H. Rubenstein
DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
12/21/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. NORMAN H. RUBENSTEIN | | | | | | 22e. ADDRESS
11161 NEW HAMPSHIRE AVE. SSPG, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
12-22-83 | | 23c. NAME OF CEMETERY OR CREMATORY
KING DAVID MEM GDN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
FALLS CHURCH, VA. | | |
| 24. FUNERAL DIRECTOR
110 ROCKVILLE PK. ROCKVILLE MD.
DANZANSKY-GOLDBERG MEM CHP, INC.... | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DEC 27 1983 John J. Givens | | | |

BP _____

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the integrity of the financial system and for the ability to detect and prevent fraud.

2. The second part of the document outlines the specific requirements for record-keeping. It states that all transactions must be recorded in a timely and accurate manner, and that the records must be maintained for a minimum of five years.

3. The third part of the document discusses the role of the auditor in verifying the accuracy of the records. It states that the auditor must perform a thorough review of the records and must report any discrepancies to the appropriate authorities.

4. The fourth part of the document discusses the consequences of failing to comply with the record-keeping requirements. It states that individuals or organizations that fail to comply may be subject to fines, penalties, or even criminal prosecution.

5. The fifth part of the document discusses the importance of training and education in ensuring compliance with the record-keeping requirements. It states that individuals involved in the financial system must receive appropriate training and education to ensure that they are able to perform their duties accurately and in accordance with the requirements.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|---|--|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| Mary P. Schuette | | | | Dec 30 83 | | 9:30 P.M. | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| Female | | Caucasian | | October 11, 1894 | | 89 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Washington, D.C. | | United States | | | | Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Bethesda | | Carriage Hill/Bethesda | | | | Homemaker | | Own Home | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | Montgomery | | Gaithersburg | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 14201 Turkey Foot Rd., 20878 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | |
| Patrick Thomas Moran | | Annie T. O'Donnell | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | |
| No | | 220-44-3968 | | Mr. James M. Schuette, Son,
1629 K. Street, N.W., Wash., D.C. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u>
4409
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Several Years</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>81</u> , to <u>Dec 30</u> , 19 <u>83</u> , that (I) <u>did</u> last saw the deceased alive on <u>Dec 29</u> , 19 <u>83</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | |
| <u>James W. Egan M.D.</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 12/30/83 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| James W. EGAN M.D. | | 5413 Cedar Ln 2060 Bethesda, Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | Jan. 3, 1984 | | Mt. Olivet Cemetery | | Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | JAN 9 1984 | | | | | | | |



Dec 23 1942

General Hospital, Philadelphia

CHIEF

20% 20% 20%



Robert A. ...
P. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-2939.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Florence Schulman | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-12-83 | | | | 2b. HOUR
9:56 A.M. | | | |
| SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
3-8-14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Bookkeeper | | 12b. KIND OF BUSINESS OR INDUSTRY
Commercial Stationers | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
14508 Homecrest Road, Apt. 406 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel Plotkin | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jennie Hoffman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
100-05-1032 | | 17. INFORMANT
ADDRESS
Dr. Howard M. Schulman Silver Spring, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
4413
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Possible rupture of aortic aneurysm
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
P.M. 19 | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12-1 , 19 83 , to 12-12 , 19 83 , that (I) (was) last saw the deceased alive on 12-9 , 19 83 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
R. Shah | | | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/12/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
K. H. SHAH MD | | | | 22e. ADDRESS
6121 Montrose Road Rockville MD 20852 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
12/13/1983 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Ohev Shalom Talmud Torah Congregation | | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D. C. | | | | 23e. DATE REC'D. BY REGISTRAR
DEC 15 1983 | | | | REGISTRAR'S SIGNATURE
John J. Conner | | | |
| DONOR: STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | | | | | | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | |
|--|--|---|--|---|-----------------------------|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Julia Helen Sealing</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>12 29 83</i> | | 2b. HOUR
<i>110 A.M.</i> | | | | | | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>8 21 1899</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>84</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery Co., MD.</i> | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Rockville</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Thomas Valley N. Center</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Sales</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Retail</i> | | | | | |
| 13a. STATE
<i>Maryland</i> | | | | | | 13b. COUNTY
<i>Howard</i> | | 13c. CITY OR TOWN
<i>Simpsonville</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
<i>6767 Old Columbia Rd. 21150</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Alfred Moore</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Julia Ann Lager</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>no</i> | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>213-28-2154</i> | | 17. INFORMANT
ADDRESS
<i>Ms Helen Deller No. 804 65 Simpsonville Md 21150</i> | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Adenocarcinoma of breast</i>
<i>1749</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>4 yrs</i> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 27</i> , 19 <i>83</i> , to <i>29 Dec</i> , 19 <i>83</i> , that (I) (was) lost saw the deceased alive on <i>27 Dec</i> 19 <i>83</i> and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Donald E. Dillon M.D.</i> | | | | | | DEGREE | | 22c. DATE SIGNED
<i>29 Dec 83</i> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Donald E. Dillon, M.D.</i> | | | | | | 22e. ADDRESS
<i>1811 Pr. Philip Dr Olney, Md 20832</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(IF ANY)
<i>BURIAL</i> | | | | 23b. DATE
<i>12-31-83</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>St. John's Lutheran Cem.</i> | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Pattons Cr. Howard MD</i> | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>SLACK FUNERAL HOME</i> | | | | ADDRESS
<i>20-Box 268 Ellicott City 21093</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>JAN 3 1984</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Connelley</i> | | | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JAMES EDWARD SHANNON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 - 26 - 83 | | | 2b. HOUR
1820 PM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 28, 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY)
MONTHS DAYS HOURS MIN.
59 YRS. | | 7. IF UNDER 1 YEAR
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pawtucket R.I. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADV. HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Chemist | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Potomac | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HUGH SHANNON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGARET SMITH | | | 13e. STREET ADDRESS / ZIP CODE
9217 Willow Pond Lane 20854 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO.
037-12-0696 | | 17. INFORMANT
ADDRESS
Mrs. Lois A. Shannon-Wife Potomac, Md. 20854 | | | | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
9110
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(c) ASPIRATION OF GASTRIC CONTENTS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 HRS
5 MIN | |
|---|--|---|--|

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **ALCOHOL INTOXICATION (ETHANOL 388MG%)**

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 25, 1983 to Dec 26, 1983 , that (I) (we) lost the deceased only on Dec 26, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Mark Birns MD | | | | DEGREE
MD | | 22c. DATE SIGNED
12/27/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARK BIRNS, MD | | | | 22e. ADDRESS
9715 MEDICAL GR DR #300, ROCKVILLE, MD | | | |

| | | | | | | | |
|--|--|----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
Dec 30, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount St. Mary's Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pawtucket Rhode Island | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
W. W. Chambers Co. 8655 Georgia Ave., S.S. Md 20906 | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1984 | | 25b. REGISTRAR'S SIGNATURE
John J. Connelley | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked or item 18 states only injury, or other traumatic event, the medical examiner must be notified immediately.

BP

Handwritten notes and diagrams on lined paper, including a vertical list of boxes at the top and various scribbles and text throughout.

Vertical list of boxes (top):

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- Box 3
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- Box 5
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- Box 10
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- Box 98
- Box 99
- Box 100

Handwritten text (top):

Handwritten text (middle):

Handwritten text (bottom):

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|--|---|-----------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARTHA M. SHAW | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/14/83 | | 2b. HOUR
MIN.
9:25 A | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
AUG 21 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
87 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
GAITHERSBURG | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANCIS ASBURY HEALTH CENTER | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
MONT. | | 13c. CITY OR TOWN
GAITHERSBURG | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HOMER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ETOILE ELIZ CRANDALL | | 13e. STREET ADDRESS
301 RUSSELL AVE | | 20877 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
578-66-6945 | | 17. INFORMANT
ADDRESS
BERTHA M. MELICK, RT. 2 HANCOCK MD | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **4280**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **congestive heart failure**

DUE TO, OR AS A CONSEQUENCE OF

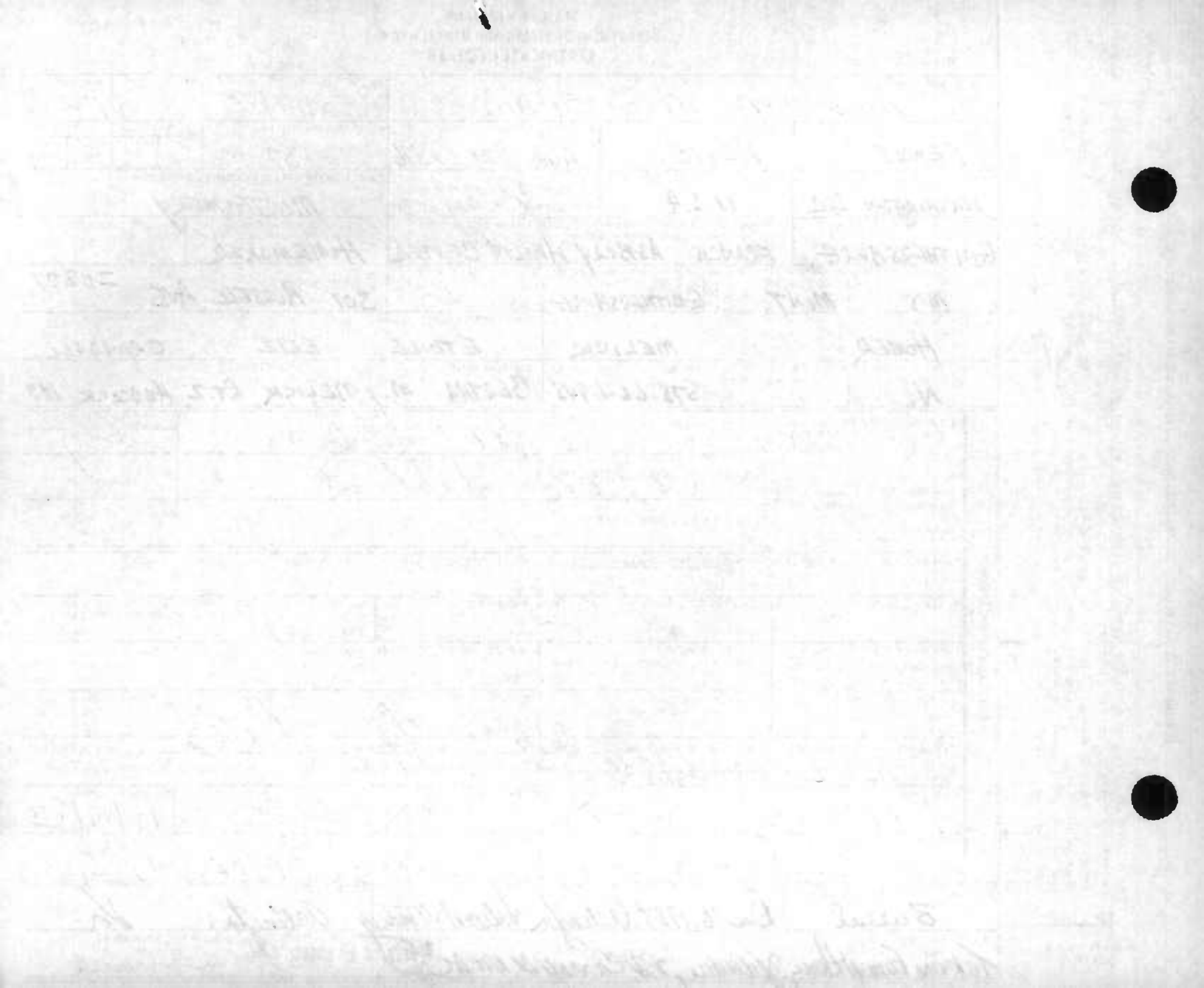
(c) **chronic failure**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 day

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY WITHIN 18 PART 1 OR PART 2) | | | |
| 21a. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/10/83 to 12/14/83 that (I) (we) last saw the deceased alive on 12/10/83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | |
| 22b. SIGNATURE
Thos G. Ward | | DEGREE | | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>
PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/14/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thos G. Ward | | 22e. ADDRESS
6116 Binwood, Bethesda, Md 20817 | | | | | |

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec 16, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Va | |
| 24. FUNERAL DIRECTOR
NAME
Takoma Funeral Home, Silver Spring, Md | | ADDRESS
250 Carroll St NW DC | | DATE
DEC 19 1983 | | REGISTRAR'S SIGNATURE
John E. Carver | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) William Pitt Shearman Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 18 '83 | | 2b. HOUR
0645^{AM} | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 12, 1896 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hosp | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Schoolcraft Shearman | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Graden | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW 1 | | 17. INFORMANT
Henrietta G. Shearman, same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiopulmonary arrest
4275
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Probable thrombogenic sepsis, diabetes mellitus | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> OR WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-17 19 83 , to 12-18 19 83 , that (I) (we) last saw the deceased alive on 12-17 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Donald L. Bucy | | DEGREE
MD | | 22c. DATE SIGNED
12-18-83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Donald L. Bucy | | 22e. ADDRESS
809 Queens Mill Rd Rockville | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 21, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | 24. FUNERAL DIRECTOR
ADDRESS
Homes, P.A. Rockville, Maryland 20850 | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1983 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. Lohr | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



CHIEF OF
BUREAU OF
LANDS

[Faint, mostly illegible handwritten text and lines across the page, possibly representing a ledger or report.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>CELIA Mae SHEEKS</i> | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>12 / 17 / 83</i> | | 2b. HOUR
<i>12⁰⁵ AM</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>CAUCASIAN</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>7 02 96</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>87</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>OHIO</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>MONTGOMERY</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>MD.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Holy Cross Hosp.</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Home</i> | |
| 13a. STATE
<i>Md.</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Rockville</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Lester Zimmerman</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Emma Evel</i> | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>NO</i> | | | |
| | | 16b. SOCIAL SECURITY NO.
<i>276-05-5466</i> | | 17. INFORMANT
<i>Marjorie Gilliland (Daughter)</i>
ADDRESS
<i>same as 13c</i> | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>CARDIOVASCULAR ARREST</i>
<i>4310</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Stroke → ICD</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Left hemispheric cerebral hemorrhage</i> | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>11/30/83 to 12/18/83</i> |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/30</i> , 19 <i>83</i> , to <i>12/18</i> , 19 <i>83</i> , that (I) (we) lost
saw the deceased alive on <i>12/18</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Bernard Stork</i> | | DEGREE
<i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>12/18/83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>BERNARD STORK MD</i> | | 22e. ADDRESS
<i>5530 WHEELER AVE CHICKADEE</i> | | | | | |

| | | | | | | | |
|--|--|------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>12/21/83</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Ashland Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Ashland Ohio</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>Tyson Wheeler Funeral Home, Inc.</i>
ADDRESS
<i>1331 Rockville Pike Rockville, Maryland 20852</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 23 1983</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Cahill</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JEANETTE SHEGAL | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 26 83 | | 2b. HOUR
6¹⁰ PM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
YEAR
APR. 20, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
GERMANY | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON HEBREW HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY
RETAIL | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY CITY OR TOWN
MARYLAND BALTIMORE | | | | 13b. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
SOLOMON LOWENSTEINER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
HELENE FIRNBACHER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
215-30-7456 | | 17. INFORMANT
ADDRESS
MRS. ELLEN JAFFE
7 ECHO CT. POTOMAC, MD #20854 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
3349 IMMEDIATE CAUSE (a) Cerebellar Degeneration
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hrs. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
DECUBITUS ULCERS OF LEGS | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/2 83 , to 12/21 83 , that (I/we) last saw the deceased alive on 12/16 83 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (I/we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
MD | | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>
PHYSICIAN DIRECTOR PHYSICIAN | | 22c. DATE SIGNED
12/27/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT L. ROSENBERG, MD | | 22e. ADDRESS
10113 GEORGETOWN AVE, #107, SILVER SPRING, MD 20902 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
DEC. 28, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
HEBREW FRIENDSHIP | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 30 1983 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |
| 6010 REISTERSTOWN RD BALTO MD 21215 | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

CHURCH OF ENGLAND



CHURCH

OF

ENGLAND

CHURCH

OF ENGLAND

CHURCH OF ENGLAND

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME OR TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17
(VR A15 ME (5))
15M/7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

33836

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST Anil | | MIDDLE D. | | LAST Shenai | | 2a. DATE KNOWN OF DEATH | | MONTH <input checked="" type="checkbox"/> DAY 12 YEAR 83 | | 2b. HOUR 11:30 | | | |
| 3. SEX White | | 4. RACE Asian Indian | | 5. DATE OF BIRTH
MONTH 6 DAY 24 YEAR 56 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 27 YRS. | | IF UNDER 1 YR.
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | | 2c. DATE PRONOUNCED DEAD
MONTH 12 DAY 8 YEAR 83 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
India | | 7b. CITIZEN OF WHAT COUNTRY?
India | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Programmer | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Computer | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6700 Wilson Lane 20817 | | | | | | | |
| 14. FATHER'S NAME
FIRST Deena MIDDLE Khalkhate LAST Shanta | | | | 15. MOTHER'S MAIDEN NAME
FIRST Panandikar MIDDLE Panandikar LAST Panandikar | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO.
214-70-0929 | | 17. INFORMANT
Avinash Bhagwat, 7904 Carteret Road Bethesda, Maryland 20817 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) asphyxiation
DUE TO, OR AS A CONSEQUENCE OF
(b) Carbon monoxide
DUE TO, OR AS A CONSEQUENCE OF
POISONING
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Keshu Tauber | | | | TITLE (SPECIFY)
Deputy | | | | MEDICAL EXAMINER
Bethesda | | | | DATE SIGNED 12-9-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
John Tauber | | | | ADDRESS 8218 Wisconsin Ave | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | | 23b. DATE
12/10/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | | | 23d. LOCATION
CITY OR TOWN Suitland, Maryland COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1983 | | | | | | | | 25b. REGISTRAR'S SIGNATURE
John J. Gwiler | |

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5015

DOI: 10.1002/for

2000

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FIGS. 1 and 2. *Phrynosoma*

1550-1551

[illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 3 3 8 3 7
REG. NO. | |
|--|--|----------------------|--|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) XXXXXXXX Mr John Richard Sherbert, Jr. | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12 18 83 | | 2b. HOUR 1:13am | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 12 15 22 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | | 7. DATE PRONOUNCED DEAD 12 18 83 19 | | 2d. HOUR 1:13am | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist HOsptial | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) General Manager | | | 12b. KIND OF BUSINESS OR INDUSTRY Const. IND | | |
| 13a. STATE Maryland | | | 13b. COUNTY Pr George | | | 13c. CITY OR TOWN Marlow Hts. | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 4011 Leisure Dr 20031 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John R. Sherbert, Sr. | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Griffith | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. WWII | | 17. INFORMANT ADDRESS John R. Sherbert III | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
4291 IMMEDIATE CAUSE (a) Acute myocardial inf.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Chronic myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Yrs. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
None | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers | | | | | | TITLE (SPECIFY) M.D. | | | DATE SIGNED 12/18/83 | | |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers | | | | | | ADDRESS 1919 Seminary Rd. Sil Spr. Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE 12-20-83 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md | |
| 24. FUNERAL DIRECTOR NAME Robert E. Wilhelm | | | | | | ADDRESS Suitland, Md. | | | 25a. DATE REC'D. BY REGISTRAR DEC 28 1983 | | |
| 25b. REGISTRAR'S SIGNATURE John S. Rogers | | | | | | | | | | | |

BP _____

TO THE DIRECTOR, NATIONAL TRAINING CENTER FOR THE DEAF
FROM THE DIRECTOR, BUREAU OF THE DISTRICT OF COLUMBIA
SUBJECT: [Illegible]

[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a memorandum or official letter. The text is too faded to transcribe accurately.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Claude J. Shiflet Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-2-1983 | | | 2b. HOUR
2:50P M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 12 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Carriage Hill Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Realtor(Ret) | | 12b. KIND OF BUSINESS OR INDUSTRY
Real Estate | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. 20816 | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Jackson Shiflet | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nora Huffman Knott | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | |
| 16b. SOCIAL SECURITY NO.
577-05-6516 A | | | 17. INFORMANT
ADDRESS
Claude J. Shiflet, Jr. Same as item 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4280 CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 WEEKS | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
DIABETES MELLITUS | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 12-2-1983 , that (I) (we) last saw the deceased alive on 12-1-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
James Mackin MD | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
DEC 2 1983 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES MACKIN MD | | | 22e. ADDRESS
5401 WESTERN AVE WASH DC 20015 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/6/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Maryland. | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph Gaudler's Sons Inc. | | | ADDRESS
5130 Wisc. Ave., N.W. Wash., D.C. | | 25a. DATE REC'D. BY REGISTRAR
DEC 7 - 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

| | | | |
|-----------------|---------------|----------------------|-----------------|
| Male | White | W. 12 1901 | 88 |
| Virginia | U.S.A. | XX | |
| Mr. 20816 | Montgomery | 4809 | 4809 |
| William Jackson | William | Knott | Knott |
| No | 727-02-6216 A | Glauco L. Smith, Jr. | Same as item 15 |

12/6/1983
 Joseph Smith's Sons Inc.
 5130 Mac. Ave. N. Wash., D.C.
 Burial
 Lincoln Cemetery
 Brentwood Maryland.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|--------------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | MONTH DAY YEAR | | MONTHS DAYS HOURS MIN. | |
| FIRST MIDDLE LAST
MARY ELLEN SHIVLEY | | December 25, 1983 | | 6:32p M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| Female | White | MONTH DAY YEAR
October 11, 1921 | 62 YRS. | Montgomery County MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Indiana | USA | | Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Bethesda | NIH, The Clinical Center | | Cook | | Public School |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Indiana | | Huntington | YES <input type="checkbox"/> NO <input type="checkbox"/> | 4554 W. 100 South 46750 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | |
| Homer Hoover | | Verda Souwers | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | 17. INFORMANT ADDRESS | | | |
| no | 305-14-5687 | Mr. Bernard Shivley (same) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cardiorespiratory arrest | | | | | 10 min. |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Myocardial infarction | | | | | 12 days |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Renal insufficiency | | | | | 4 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | |
| 12 days of support with left ventricular assist device and intra aortic balloon | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| December 13, 1983 | Idiopathic hypertrophic subaortic stenosis | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | |
| 22a. I certify that (this hospital) attended the deceased from November 5, 1983, to December 25, 1983, that (we) lost
saw the deceased alive on December 25, 1983, and that in (our) opinion death occurred on the date and hour and from the causes stated
above, (we) (did) (not) view the body after death. | | | | | |
| 22b. SIGNATURE
Dr. David J. Underhill | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/26/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. DAVID J. UNDERHILL | | 22e. ADDRESS
National Institutes of Health, 9000
Rockville Pike, Bethesda, Maryland 20205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| Removal | 12-27-83 | Deal & Robbins F/H | Huntington, Indiana | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Marshall's Funeral Home
4217 9th Street NW: Washington, D.C. | | 25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE
JAN 03 1984 John J. Conner | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33840

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|---------------------|--|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Norman Hurst Shoemaker</i> | | | 2b. DATE OF DEATH
KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <i>Dec 20 1983</i> | | | 2c. DATE PRONOUNCED DEAD <i>Dec 20 1983</i> | | |
| 3. SEX
<i>M</i> | 4. RACE
<i>W</i> | 5. DATE OF BIRTH
MONTH DAY YEAR <i>Dec 27 1966</i> | 6. AGE (IN YEARS)
LAST BIRTHDAY <i>66</i> YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS | 8. IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Penna.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | |
| 10. CITY OR TOWN OF DEATH
<i>Tak Park</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Wark. Stuart Hosp</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK)
<i>Asst. Mgr. Grounds</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
<i>MD</i> | | | 13b. COUNTY
<i>Montg.</i> | 13c. CITY OR TOWN
<i>Tak Park</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
<i>7019 Holly Ave</i> 20912 | | |
| 14. FATHER'S NAME
FIRST <i>John</i> MIDDLE <i>H</i> LAST <i>Shoemaker</i> | | 15. MOTHER'S MAIDEN NAME
FIRST <i>Emma</i> MIDDLE <i>Hurst</i> LAST <i>Hurst</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) <i>Yes</i> | | 16b. SOCIAL SECURITY NO.
<i>US Navy</i> | | 17. INFORMANT
<i>Patricia M. Shoemaker (Wife)</i> | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY:
<i>4291 Acute Myocardial Dis</i>
IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i> | | | | | | | | |
| 19a. DATE OF OPERATION
<i>None</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE <i>John J. Gough</i> | | | | TITLE (SPECIFY)
M.D. <i>Dep.</i> | | MEDICAL EXAMINER | | DATE SIGNED <i>Dec 20 1983</i> |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
<i>Burial</i> | | 23b. DATE
<i>Dec. 30, 1983</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Minnonite Ch. Cem.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Chambersburg, Penna.</i> | | |
| 24. FUNERAL DIRECTOR
<i>John J. Gough</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 30 1983</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Gough</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 1.

MEDICAL CERTIFICATION

| FOR
1 - STATE
REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
VERA Siegel | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/22/83 | | | | 2b. HOUR
1:55 AM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
MARCH 17, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Latvia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4604 DeRussey Parkway (20815) | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Louis Wolk | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Miriam Koblentz | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | |
| 16a. SOCIAL SECURITY NO.
578-05-3907 | | | | 17. INFORMANT
ADDRESS
Virginia 22151
Melvin Siegel; 6048 Havenhill Ct.; Springfield | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
<u>5609</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) <u>SEPSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>INTESTINAL OBSTRUCTION</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u>
<u>7 days</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Atherosclerotic Heart Disease, Atherosclerotic Cerebrovascular disease</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>July</u> 19 <u>83</u> , to <u>DEC 22</u> 19 <u>83</u> , that (1) (we) lost
saw the deceased alive on <u>DEC 21</u> 19 <u>83</u> , and that in (m) (our) opinion death occurred on the date and hour and from the causes stated
above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Robert L. Rosenberg</u> | | | | DEGREE
MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12/22/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT L. ROSENBERG MD | | | | 22e. ADDRESS
10313 GEORGETOWN AVE, SILVER SPRING MD 20902 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
12/23/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Lebanon Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Adelphi; Prince Geo.; Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
DANZANSKY-GOLDBERG MEMORIAL CHAPELS | | | | 24b. ADDRESS
1170 Rockville Pike; Rockville, Maryland 20852 | | | | 25a. DATE REC'D BY REGISTRAR
DEC 27 1983 | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>John J. Lohr</u> | | | | | | | | | | | |

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 3 8 4 2

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|---------------------|--|---|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
<i>Henry Alfred Siekman</i> | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
<i>Dec 24 1983</i> | | | 2b. HOUR
10 M | | |
| 3. SEX
<i>M</i> | 4. RACE
<i>W</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>Jan 9 09 75</i> | 6. AGE (IN YEARS)
LAST BIRTHDAY
<i>75</i> YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
<i>Dec 24 1983</i> | 2d. HOUR
10 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Massachusetts</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery MD.</i> | | |
| 10. CITY OR TOWN OF DEATH
<i>St. Louis</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Rely Cross Hosp</i> | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Inventory Super.</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Draper Lab</i> | |
| 11a. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)
STATE
<i>Mass</i> | | 13. CITY OR TOWN
<i>Middlesex</i> | | 13a. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13b. STREET ADDRESS
<i>99999 150 Mass Ave</i> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Anthony Siekman</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Mary Danner</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
<i>No</i> | | | 16b. SOCIAL SECURITY NO.
<i>011 09 7011</i> | | 17. INFORMANT
ADDRESS
<i>Mary Macko, 1901 Mica Dr., Silver Spring,</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i>
<i>4291</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) <i>Chronic Myocardial Infarction</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<i>None</i> | | | | | | | | |
| 19a. DATE OF OPERATION
<i>None</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
<i>John S. Rogers</i> | | | | TITLE (SPECIFY)
<i>M.D. Dep</i> | | MEDICAL EXAMINER | | DATE SIGNED
<i>Dec 24 1983</i> |
| EXAMINER'S NAME
(TYPE OR PRINT)
<i>John S. Rogers, M.D.</i> | | | | ADDRESS
<i>1919 Seminary Rd., Sil.Sp., Md.</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>Dec. 28, 83</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Westview Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Lexington, Mass.</i> | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Arlington Funeral Home</i> | | | | 25a. DATE RECD. BY REGISTRAR
<i>DEC 29 1983</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Carver</i> | | |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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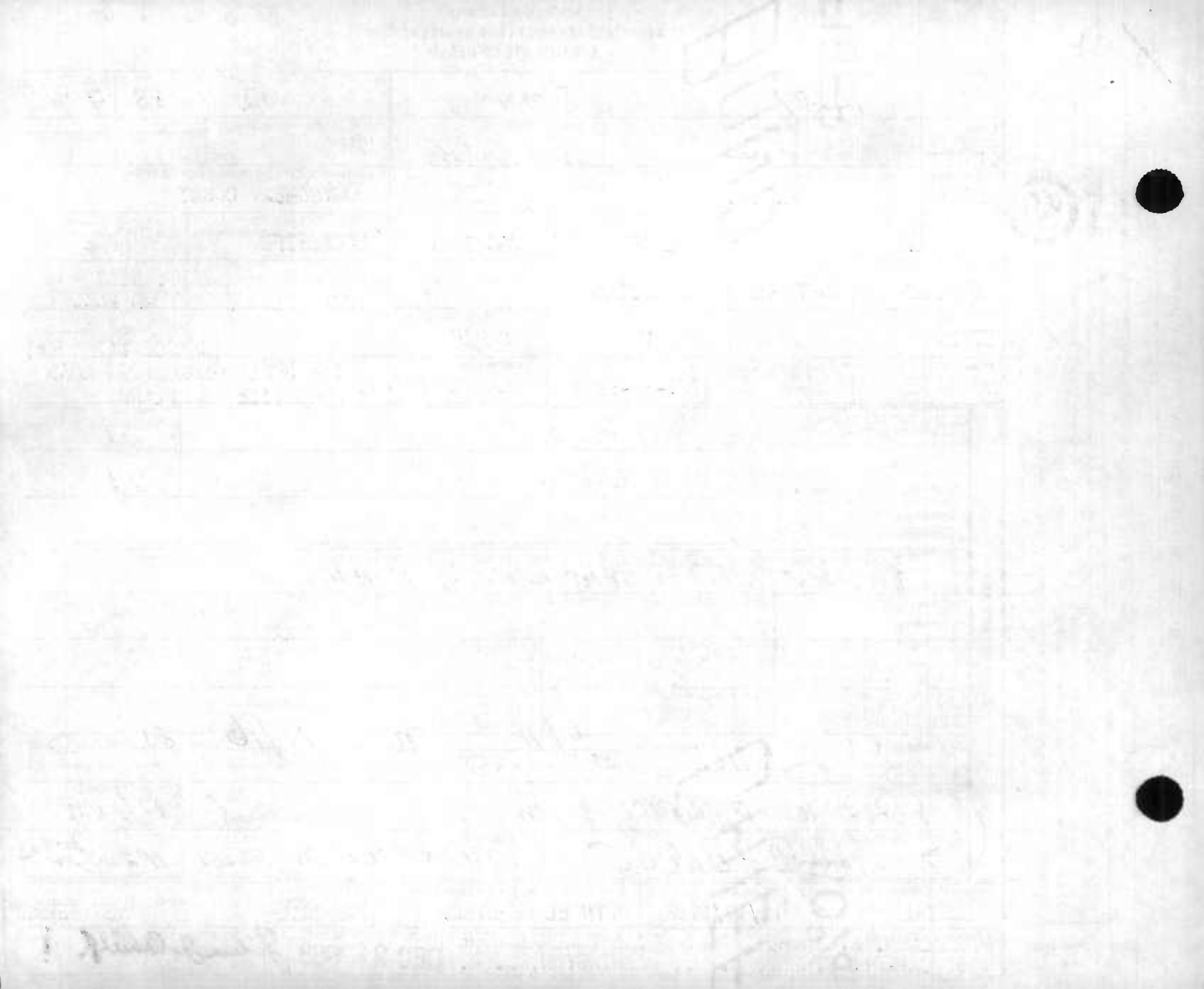
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BP.



STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
GEORGIE ISABELLE SIMPSON | | | 2a. DATE OF DEATH MONTH DAY YEAR
DECEMBER 31, 1983 | | 2b. HOUR
5:08 ^a _M |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
AUGUST 6, 1921 | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8. MARRIED <input type="checkbox"/> NEVER MARRIED XX
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. NAVY | |
| 13a. STATE
MARYLAND | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
GAITHERSBURG | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO XX | 13e. STREET ADDRESS / ZIP CODE
9926 WALKER HOUSE RD. #3 20879 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE FRANCIS SIMPSON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ZEPHA BLANCHE ANDERSON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1943-1967 | 17. INFORMANT
ADDRESS
TAYLOR SIMPSON, 1717 BRANDON DR, WINCHESTER, VA. 22601 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4275 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES XX NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES XX NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 28 , 19 83 , to DECEMBER 31 , 19 83 , that (I) (further) last saw the deceased alive on DECEMBER 31 , 19 83 , and that in (my) (further) opinion death occurred on the date and hour and from the causes stated above, (I) (further) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Joseph P. Coyle</i> | | | | 22c. DATE SIGNED
1 JAN 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOSEPH PAUL COYLE, LT, MC, USNR | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD. 20814 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
1984 January 4 | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria Virginia | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey | | ADDRESS
Federal Homes, PA Rockville Maryland 20850 | | 25a. DATE REC'D. BY REGISTRAR
JAN 9 1984 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the name of the deceased, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination may be required.



[Handwritten signature]

1885

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. FOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|------------------|--|---------------------------------|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DECEASED NAME (TYPE OR PRINT) Harold Leslie Simpson | | 2b. DATE KNOWN OF DEATH Dec 24 1983 | | 2c. DATE PRONOUNCED DEAD Dec 28 1983 | | 2d. HOUR 11:10 PM | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH Nov 3 1917 | 6. AGE (IN YEARS) 66 YRS | 7. IF UNDER 1 YR. MONTHS 0 DAYS 0 | 8. IF UNDER 24 HRS. HOURS 0 MIN. 0 | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | 10. CITY OR TOWN OF DEATH Tk. Park | |
| 11. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Programmer | | 15. KIND OF BUSINESS OR INDUSTRY W.M.A.T.A. | |
| 16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 207 Boyd Ave Apt. 4 | | 17. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 207 Boyd Ave Apt. 4 | | 18. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 19. STREET ADDRESS 307 Boyd Ave Apt. 4 | | 20. ADDRESS 230 Curtis Street, Pittsburgh, Pa. 15235 | |
| 11a. FATHER'S NAME FIRST Andrew MIDDLE Leslie LAST Simpson | | 11b. MOTHER'S MAIDEN NAME FIRST Emma MIDDLE J. LAST Clager | | 12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | 12b. SOCIAL SECURITY NO. WWII 160-12-4921 | | 12c. INFORMANT Mr. Paul Simpson | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
4291
IMMEDIATE CAUSE (a) Acute Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | TITLE (SPECIFY) Dep. | | DATE SIGNED Dec 30 1983 | | M.D. John J. Connel | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Jan. 3 - 1984 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Colmar Manor, P.G. Md. | | 23e. FUNERAL DIRECTOR NAME Arthur Walters | |
| 23f. FUNERAL HOME Takoma Fun'l Home, Inc. | | 23g. ADDRESS 644 Carroll St. N.W. Wash., D.C. 20012 | | 23h. DATE REC'D. BY REGISTRAR JAN 5 1984 | | 23i. REGISTRAR'S SIGNATURE John J. Connel | | 23j. REGISTRAR'S NAME | |

BP

Harold Leslie

Thomas J. ...

Andrew Leslie ...

For ...

10-22-2001

10-22-2001

Column ...

10-22-2001



33646

1 - FOR
STATE
REGISTRAR

I. DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST
Edna W. Small

| | | | | |
|-------------------|-------|----------|------|----------|
| 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| | | 12-26-83 | | 7:52P.M. |

3 SEX
Female

4. RACE
White

5 DATE OF BIRTH
MONTH DAY YEAR
Sept. 24, 1895

| | | | | |
|--------------------------------|-----------------|------|-----------------|-----|
| 6 AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| | MONTHS | DAYS | HOURS | MIN |
| 88 YRS | | | | |

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.J.

7b CITIZEN OF WHAT COUNTRY?
USA

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH
montgomery MD

10. CITY OR TOWN OF DEATH
Wheaton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Nursing Home

| | |
|---|-------------------------------------|
| 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b KIND OF BUSINESS OR
INDUSTRY |
| School Teacher | N. J. School |

| | | |
|---|-------------|-------------------|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN |
| Maryland | Mont. | Wheaton |

13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 901 Arcola Avenue 20902

4 FATHER'S NAME
FIRST MIDDLE LAST
Frederick W Weber

| | | |
|--------------------------|--------|------|
| 15. MOTHER'S MAIDEN NAME | | |
| FIRST | MIDDLE | LAST |
| Elizabeth Dechand | | |

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

| | | |
|-------------------------|---------------------|---|
| 16b SOCIAL SECURITY NO. | 17 INFORMANT | ADDRESS |
| 120-24-1820 | Sen. James C. Small | 11804 Renick Lane
Silver Spring, Md. |

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia

4292

CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last

{ DUE TO, OR AS A CONSEQUENCE OF (b) Ascus

{ DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 DAYS

10 YRS.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | |
|------------------------|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|--|--|---|

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

| | | | | |
|---------------------|------|-------|-----|------|
| 21b. TIME OF INJURY | | | | |
| HOUR | A.M. | MONTH | DAY | YEAR |
| 8 | P.M. | 10 | 10 | 19 |

| | |
|--|--|
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| | |

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

| | | | | |
|--------------|--------------|--------|-------|--|
| 211 LOCATION | | | | |
| STREET | CITY OR TOWN | COUNTY | STATE | |

22a. I certify that (I) (the hospital) attended the deceased from 1-, 19 23, to 12-26, 19 83, that ~~we~~ (we) lost
saw the deceased alive on 12-21, 19 83, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated

above, we (we) did (did not) view the body after death.

22b. SIGNATURE [Signature] DEGREE [Blank] ATTENDING ☐ MEDICAL ☐ STAFF ☐

22c. DATE SIGNED 12/26/03

| | | | |
|--|--|--|--|
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
WAITER GREGG | | 22e ADDRESS
3328 Shoreside Blvd Downbeat, 20902 | |
|--|--|--|--|

| | | | | | |
|---|------------|------------------------------------|-------------------------------|--------|-------|
| BURIAL, CREMATION, REMOVAL
(SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN | COUNTY | STATE |
| Burial | Dec 30 183 | Lake Park Cemetery | Sturbridge | W. T. | |

| | | | |
|-------------------|--------------------|-------------------------------|----------------------------|
| UNCLERK DIRECTION | DeVol Funeral Home | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| NAME | ADDRESS | | |
| <i>John DeVol</i> | Washington, D.C. | <i>11 AM 5 1981</i> | <i>De 2. Smith</i> |

BE

JAN 5 1984

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Barbara JANE SMITH | | 2a. DATE OF DEATH MONTH DAY YEAR December 30, 1983 | |
| 3. SEX Female | | 2b. HOUR 8:55 pm | |
| 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR October 4 1910 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oregon | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | |
| 10. CITY OR TOWN OF DEATH Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 1st. Col. U. S. Army | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | |
| 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS 3439 S. Leisure World Blvd #10 | | 13f. ZIP CODE 20906 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lloyd Rittenhouse Smith | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST STELLA LINNEHAN | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. W. W. II 541-12-6162 | |
| 17. INFORMANT Niece | | ADDRESS 6820 S.W. 26th Ave. Portland, Ore. 97211 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
5789
DUE TO, OR AS A CONSEQUENCE OF (b) Repetitive stress
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c) upper GI bleed | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/27 , 19 83 , to 12/30 , 19 83 , that (I) (we) last saw the deceased alive on 12/30 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Arthur Schenckel | | 22c. DATE SIGNED 12/31/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR SCHENCKEL | | 22e. ADDRESS 18101 Penna Phyls Dr, Bryn M | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Jan. 3, 1984 | |
| 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria | | 23d. LOCATION CITY OR TOWN COUNTY STATE Virginia | |
| 24. FUNERAL DIRECTOR NAME Francis J. Collins | | 25a. DATE REC'D. BY REGISTRAR JAN 9 1984 | |
| 25b. REGISTRAR'S SIGNATURE John J. Labick | | 25c. ADDRESS 500 University Blvd., W. Silver Spring, Md. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examination is required if the death is due to violence, poisoning, or other suspicious cause. The medical examiner must be notified of death. The low requires that the death certificate be executed within 24 hours after death. Post-mortem examination is required if the death is due to violence, poisoning, or other suspicious cause. The medical examiner must be notified of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

TO : SAC, NEW YORK (100-100000) FROM : SAC, NEW YORK (100-100000) (P)
SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]



RECEIVED
FBI NEW YORK
JUN 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

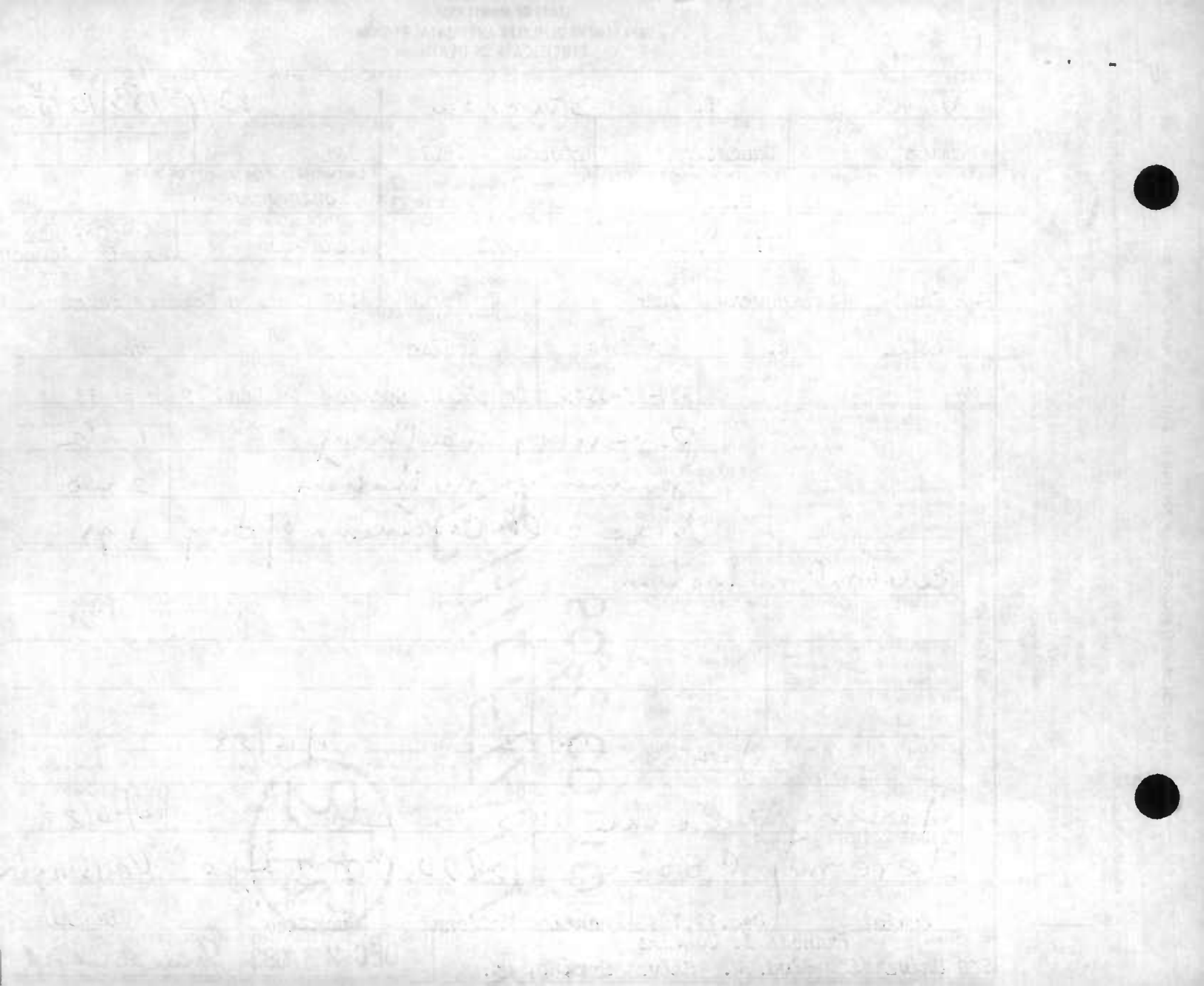
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
Nancy B. Sparrow | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12/15/83 | | | | 2b. HOUR MIN.
10:30 P.M. | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
October 28 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7. IF UNDER 1 YEAR HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4112 Charley Forest Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
Defense Mapping Agency | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Olney | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4112 Charley Forest Street 20832 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Leslie R. Bradshaw | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Louise Evans | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
579-28-5545 | | 17. INFORMANT ADDRESS
Donald U. Sparrow Husband Same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u>
1629
DUE TO, OR AS A CONSEQUENCE OF (b) <u>pulmonary metastases</u>
2 mo.
DUE TO, OR AS A CONSEQUENCE OF (c) <u>large cell carcinoma of lung</u>
1 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>Cerebral metastases</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/12/83</u> to <u>1/16/83</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>11/22/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Jeremy N. Cooke | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/16/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jeremy Cooke | | | | 22e. ADDRESS
10400 Cmm Ave. Kensington | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Dec. 19, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Quantico National | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Quantico Virginia | | | |
| 24. FUNERAL DIRECTOR NAME
Francis J. Collins | | | | ADDRESS
500 University Blvd., W. Silver Spring, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 23 1983 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | | | | | | | |

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1- FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|---|--|------------|--|---|--|-------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST John | | MIDDLE Sherman | | LAST Speaks, Jr. | | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH DAY YEAR | | 2b. HOUR | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 1 YR. | | 7. IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | |
| m | | w | | Sept 17, 28 | | 35 YRS. | | MONTHS DAYS | | HOURS MIN. | | Dec. 17, 83 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| N. Carolina | | | | USA | | | | | | | | Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Sil. Sprg | | | | McHenry Dr | | | | Clerk | | | | A&P Stores | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | |
| Md | | | | Montg | | | | Sil. Sprg | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | | |
| John Sherman Speaks | | | | Ilma Templeton | | | | N/A | | | | 242-36-4885 | | | |
| 17. INFORMANT | | | | ADDRESS | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| Harold T. Speaks-Brother | | | | P.O.Box 453 Sterling, Va. | | | | PART 1 DEATH WAS CAUSED BY: | | | | 22170 | | | |
| | | | | | | | | IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> | | | | | | | |
| | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| | | | | | | | | (b) | | | | | | | |
| | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| | | | | | | | | (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | |
| None | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | |
| None | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | |
| death resulted from | | | | | | | | | | | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | |
| John S. Rogers, DME | | | | M.D. Dep. | | | | DEC 18/1983 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | 1919 Seminary Rd. Silver Spring, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | |
| Burial | | | | Dec. 21, 1983 | | | | Gate of Heaven | | | | Silver Spring Montgomery Md. | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Hines/Rinaldi Funeral Home | | | | DEC 20 1983 | | | | John J. Bui | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR
STATE
REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|---|--|--|--|-------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Frank H. Spencer | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 13, 1983 | | | | 2b. HOUR
8:45P M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 2 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Fed. Gov't. | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Olney | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
17340 Quakers Lane 20832 | | | |
| 4. FATHER'S NAME
FIRST MIDDLE LAST
John L. Spencer | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Fannie B. Budden | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
220 42 0316M | | 17. INFORMANT
ADDRESS
Hallie Spencer (Wife) Same as 13E | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4140
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic + Giant Cell Arteritis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Giant Cell Arteritis involving brain, heart, kidney
(c) Years | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
uremia - days
Years | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Aortic Stenosis to Left Ventricular Failure | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12 Dec 1978 to 13 Dec 1983 , that (I) (not) lost saw the deceased alive on 12 Dec 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Gustavo S. Belaval | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/14/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gustavo S. Belaval MD | | | | 22e. ADDRESS
3701 Rossmoor Blvd. S.S. Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/17/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood PG Maryland | | | | | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 20 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | | | |

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ANALYSIS

BY

WOODWARD

DM.S.2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | |
|--|--|---|--|---|---|---|---|--|--|-----------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Edward Joseph Spindler | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 18, 1983 | | | 2b. HOUR
1:17 A.M. | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 21, 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, DC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital, | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Policeman | | 12b. KIND OF BUSINESS OR INDUSTRY
D.C. Police | | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 12c. STREET ADDRESS
4606 Brad Court 20853 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Spindler | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Agnes Sheehan | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
Korean | | 17. INFORMANT
ADDRESS
Rosemary Spindler-wife- (same as 13c) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4100 Ventricular Fibrillation
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Ischemia
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Heart Disease | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
45-50 mins.
4-5 days
6-18 months | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Acute Anterior Myocardial Infarct 11/7/83 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21i. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from 12-12, 1983, to 12-18, 1983, that (I) (we) lost saw the deceased alive on 12-18, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Herman B Segal | | | | | | DEGREE
MD. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Dec. 18, 1983 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Herman B Segal | | | | | | 22e. ADDRESS
11303 Georgia Ave Silver Spring Md | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Dec. 20, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Montgomery Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi Funeral Home Silver Spring, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 20 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DO NOT
REPLY
TO
THIS
CARD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours in the files with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | |
|---|---|--|---|
| FOR
1 - STATE
REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Inger Springer | | 2a. DATE OF DEATH MONTH DAY YEAR
Dec 11 1983 9:10 ^a M | |
| 3 SEX
FEMALE | 4 RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT. 21, 1892 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WISCONSIN | 7b. CITIZEN OF WHAT COUNTRY?
USA | 6. AGE (IN YEARS LAST BIRTHDAY)
91 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NATIONAL LUTHERAN HOME | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CASHIER | | 12b. KIND OF BUSINESS OR INDUSTRY
UNKNOWN | |
| 13a. STATE
VIRGINIA | | 13b. COUNTY
ALEXANDRIA | 13c. CITY OR TOWN
ALEXANDRIA |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
BEN HANSON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY HANSON | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
344-05-7255B | |
| 17. INFORMANT
ADDRESS
REV. DR. RICHARD REICHARD - NLH - ROCKVILLE, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4140 IMMEDIATE CAUSE (a) <i>cardiac arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>arteriosclerotic heart disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>5 yrs.</i> | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Dementia, Primary Degenerative</i> | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 6</i> , 19 <i>77</i> , to <i>Dec 11</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>Dec 9</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<i>Harold F. McCann M.D.</i> | | 22c. DATE SIGNED
12-11-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HAROLD F. MCCANN | | 22e. ADDRESS
3355-16th N.W. WASH. DC 20010 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
DEC. 14, 1983 | 23c. NAME OF CEMETERY OR CREMATORY
MT. COMFORT CEMETERY | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA, VIRGINIA |
| 24. FUNERAL DIRECTOR
NAME
THE HYSONG CO., INC. - 1300-N ST., NW WASH. DC | | 25. DATE REC'D. BY REGISTRAR
DEC 23 1983 REGISTRAR'S SIGNATURE
<i>John J. Cahill</i> | |

MEDICAL CERTIFICATION

5

100-100

1000 1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3. OBTAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 3 8 5 3

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
William ENRICO STAMATES | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
12 5 19 83 | | | 2b. HOUR
M
8:20 | |
| 3. SEX
Male. | | 4. RACE
White. | | 5. DATE OF BIRTH
DAY MONTH YEAR
Aug. 9, 1954 | | 6. AGE (IN YEARS)
LAST DAY YRS.
29 | |
| 7a. BIRTHPLACE (STATE OR COUNTRY)
Takoma Park, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
(auto) 8312 Greenwood Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
General Contractor. | |
| 13a. STATE
Maryland. | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Paul Stamates | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Suckell | | 16. STREET ADDRESS
8720 Colesville Rd. 20910 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
Not Available | | 17. INFORMANT
ADDRESS
Paul Stamates. (Brother) 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage
4310
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | | | DATE SIGNED 12-8-83 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | |

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
Burial. | | 23b. DATE
Dec. 12, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
George Washington Riggs Road, P. G. Co. Md | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
 | | 25a. DATE REC'D. BY REGISTRAR
DEC 14 1983 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

U.S. DEPARTMENT OF JUSTICE

April 1, 1963

U. S. A.

General Contractor

8750 Colossus Rd. Silver Spring, Md.

Handwritten signature

Harry

Paul Summers

Paul Summers (Brother) 193

43811

Handwritten notes and stamps

Enc. 1st 1963 and the Washington High Road, P. O. Co. Md.

Blom Travelers Inc.
254 Carroll St. N. W. D.C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 33854 | |
|--|--|----------------------|---|--|------------------------------------|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) LIANNA STANAT | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12-2-83 | | 2b. HOUR 8:01A | | 2c. DATE PRONOUNCED DEAD 12-2-83 | |
| 3. SEX Female | | 4. RACE Cauc. | | 5. DATE OF BIRTH October 10, 1983 | | 6. AGE (IN YEARS LAST BIRTHDAY) 1 YRS. 122 | | 7. DATE PRONOUNCED DEAD 12-2-83 | | 7b. HOUR 8:01A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? United States | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County | | |
| 10. CITY OR TOWN OF DEATH Leonardtwn | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Never Employed | | | 12b. KIND OF BUSINESS OR INDUSTRY N/A | | |
| 13a. STATE Maryland | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Zip: 20850
15101 Southlawn Lane | | |
| 14. FATHER'S NAME
FIRST Martin MIDDLE DeFranceaux LAST Patricia | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Patricia MIDDLE Stanat LAST Stanat | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT (Mother) Patricia Stanat | | | ADDRESS 15101 Southlawn Lane, Rockville, Maryland | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thermal injuries
9043
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 12/? 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) unknown | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | 21f. LOCATION
STREET 12400 Good Hill Rd. CITY OR TOWN Wheaton, Md. COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 12-2-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Dec. 7, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | 23d. LOCATION
CITY OR TOWN Silver Spring COUNTY Maryland STATE | | | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey | | | | ADDRESS Homes, P.A., Rockville, Maryland | | | | 25a. DATE RECD. BY REGISTRAR DEC 7 - 1983 25b. REGISTRAR'S SIGNATURE [Signature] | | | |



1000
1000
1000
1000



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|--|---|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Gladys D. Steinecke | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 9, 1983 | | | 2b. HOUR
8:40A M | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 12, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
(20815)
4701 Willard Avenue | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jack Naumann | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine Tracy | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
577-84-6875 | | 17. INFORMANT
ADDRESS
Druscilla Amatucci, same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>5070</u> <u>Bilateral Aspiration Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Respiratory Distress Syndrome</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 day -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u> | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN CAUSE AND DEATH
<u>5 day -</u> | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/8</u> 19 <u>83</u> to <u>12/9</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/8</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If the word "and" is not view the body after death). | | | | | | | | | 22b. SIGNATURE
<u>J. Blaine Fitzgerald</u> | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
J. Blaine Fitzgerald, M.D. | | | 22d. ADDRESS
8218 Wisconsin Avenue
Bethesda, Maryland 20814 | | | 22e. DATE SIGNED
12/9/83 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Dec. 12, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Maryland | | | |
| 24. FUNERAL DIRECTOR'S NAME
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 14 1983 | | 25b. REGISTRAR'S SIGNATURE
<u>John J. [Signature]</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



[Faint, illegible handwritten text, possibly a letter or report.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|---|----------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) DR. SAMUEL STEINHOLTZ | | December 2, 1983 | | 2:25 a.m. | |
| 1. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| Male | White | December 7, 1901 | 81 | MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Russia | USA | | Montgomery, MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Wheaton | Randolph Hills Nursing Home | Physician (Ret.) | Medical | | |
| 13a. STATE | 13b. CITY OR TOWN | 13c. STREET ADDRESS | 13d. INSIDE CITY LIMITS? | | |
| Texas | Bexar | San Antonio | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | |
| Abraham | Annie | Yes | | | |
| 16b. SOCIAL SECURITY NO. | 17. INFORMANT | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | |
| 104320965A | Mrs. Eve Sheinman | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR INSUFFICIENCY | | | |
| | | 4379 DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |
| | | (b) DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | (c) | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: RENAL FAILURE, PERIPHERAL ARTERIAL OCCLUSION | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | HOUR A.M. MONTH DAY YEAR | | | | |
| | P.M. 19 | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from OCT 4, 1980 to DEC 2, 1983 , that (1) we lost the deceased alive on DEC 2, 1983 , and that in my opinion death occurred on the date and hour and from the causes stated above, (1) we (did) view the body after death. | | | | | |
| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| <i>Martin C. Shargel</i> | M.D. | | | DEC 2, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | | | |
| MARTIN C. SHARGEL | 3720 FARRAGUT AVENUE KENSINGTON MARYLAND - 20895 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| Burial | 12-6-83 | Montefiore Cem. | St. Albans, New York | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| DANZANSKY-GOLDBERG MEMORIAL CHAPELS | | DEC 12 1983 | | <i>John J. Canine</i> | |
| 1170 Rockville Pike; Rockville, Maryland 20852 | | | | | |

20% COLL

RECEIVED



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE AND PRINT) | | MONTH DAY YEAR | | MONTHS DAYS HOURS MIN. | |
| FIRST MIDDLE LAST | | December 10, 1983 | | 10:40 P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| female | | Caucasian | | MONTH DAY YEAR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Kansas | | United States | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Bethesda | | Suburban Hospital | | montgomery county, MD. | |
| 13a. STATE | | 13b. COUNTY | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Washington, D.C. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Housewife | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | Own Home | |
| Miles | | Burden | | Margaret Bracken | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 509-48-8068 | | Guy L. Goodwin Son Same as 13c | |
| 18. CAUSE OF DEATH (Enter only one cause or line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1579 | | DUE TO, OR AS A CONSEQUENCE OF (b) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO, OR AS A CONSEQUENCE OF (c) | | 7 months | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21e. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 21f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 12/17/83 | | 12/10/83 | |
| 22a. I certify that (this hospital) attended the deceased from 12/10/83 to 12/10/83, that (we) lost (to the deceased) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | |
| J. Blaine Fitzgerald, M.D. | | 12/11/83 | | J. Blaine Fitzgerald, M.D. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Cremation | | Dec. 11, 1983 | | Metropolitan Crematory Alexandria Virginia | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland | | DEC 14 1983 | | John J. Conner | |

(M)

CHIEF-AM

10% COTTON

(S)

Robert A. Humphrey
Cremation
11, 1983

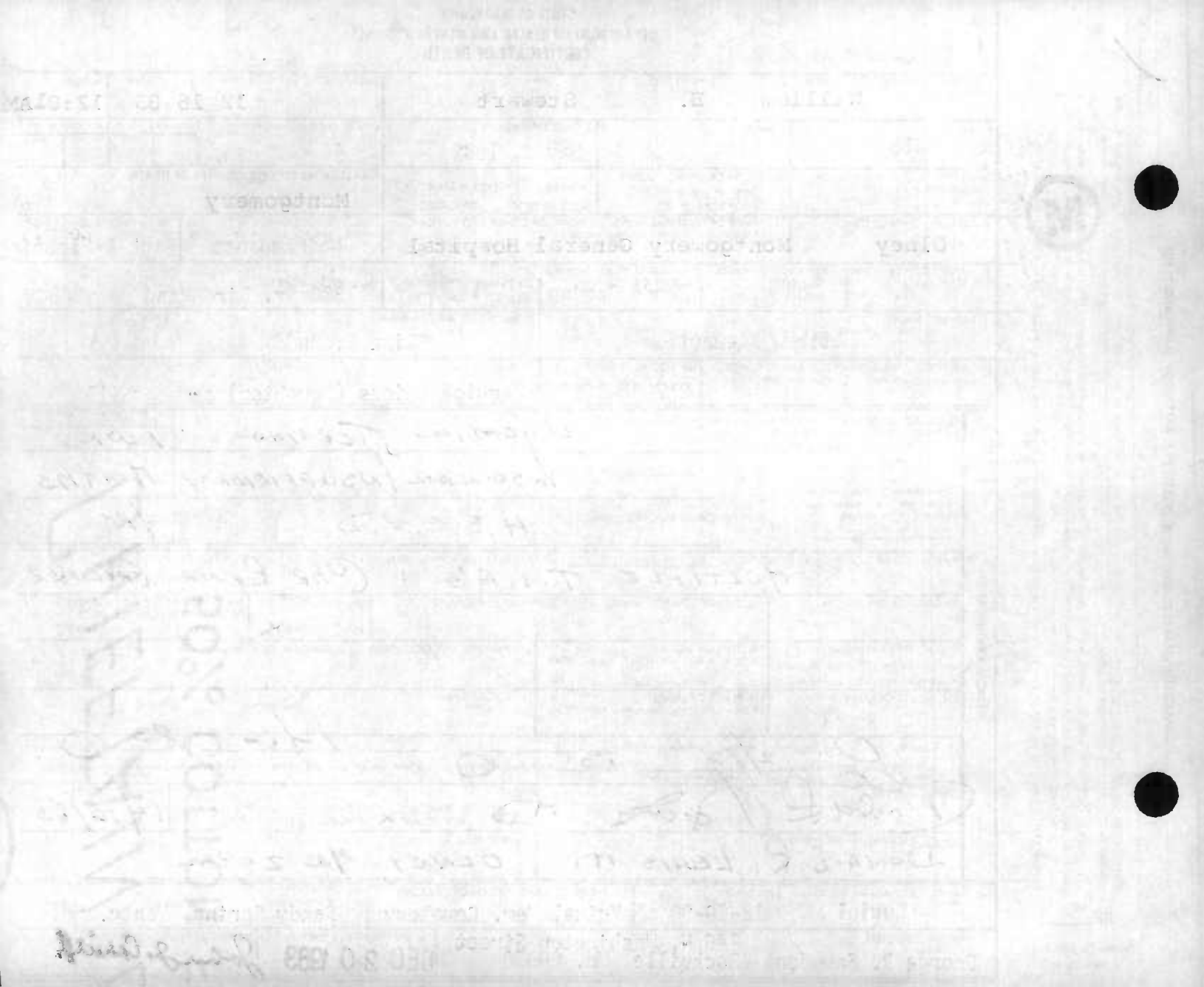
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical director must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | | | | | 33858 | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
William E. Stewart | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 16 83 | | | | 2b. HOUR
12:01 AM | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 3, 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
94 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Maintenance | | 12b. KIND OF BUSINESS OR INDUSTRY
Comm. Park & Planning | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13a. STATE
Md. | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Sandy Spring | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Matthew Stewart | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Eliza E. Budd | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-05-2639 | | 17. INFORMANT
ADDRESS
Bernice Gaines (Daughter) same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
4292 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 WK
Months
YES | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.
MULTIPLE T.I.A's : CHRONIC RENAL FAILURE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 2/16/83 to 12/16/83, that (1) (we) lost
saw the deceased alive on 2/16/83, and that (my) (our) opinion death occurred on the date and hour and from the causes stated
above (1) (we) (and) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
DONALD R. LEWIS MD | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/16/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DONALD R. LEWIS MD | | | | | | 22e. ADDRESS
OLNEY, MD 20832 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
12-20-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Mutual Mem. Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sandy Spring, Montg. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
George R. Snowden | | | | 24b. ADDRESS
246 N. Washington Street
Rockville, Md. 20850 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 20 1983 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE
John J. Carter | | | |



DEC 30 1983

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JO-CARROLL ELAINE STOHLER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 26 1983 | | | 2b. HOUR
3:45 P_M | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
APRIL 2 1945 | | 6. AGE (IN YEARS LAST BIRTHDAY)
38 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | |
| 13a. STATE
DISTRICT OF COLUMBIA | | 13b. COUNTY
COLUMBIA | | 13c. CITY OR TOWN
WASHINGTON, DC 20336 | | 13d. STREET ADDRESS / ZIP CODE
3488F SCOTT CIRCLE 99999 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES CALVIN BRICKER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LUELLA GERALDINE GUSSLER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- 168-36-6634 | | 17. INFORMANT
ADDRESS
TIMOTHY M. STOHLER, 3488F SCOTT CIRCLE, BAFB, | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART 1. DEATH WAS CAUSED BY:

2089

IMMEDIATE CAUSE (a) **LEUKEMIA**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

| | | | |
|------------------------|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|--|--|--|

| | | |
|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |

22. I certify that (I) (this hospital) attended the deceased from **DECEMBER 20, 1983**, to **DECEMBER 26, 1983**, that (I) (we) last saw the deceased alive on **DECEMBER 26, 1983**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---------------------|--|-------------------------------------|
| 22a. SIGNATURE
<i>J.P. Asher</i> | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
12/27/83 |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
JEANNE P. ASHER, LT, MC, USNR | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | |

| | | | |
|--|----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
1-3-84 | 23c. NAME OF CEMETERY OR CREMATOR
Cent Indiantown Gap Nat | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Indiantown Gap, Pa. |
| 24. FUNERAL DIRECTOR
NAME
Robt E Wilhelm
Funeral Home | | 25. DATE REC'D. BY REGISTRAR
JAN 03 1984
25b. REGISTRAR'S SIGNATURE
<i>John J. Connel</i> | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|---|--|---|-------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) DABBEY STRICHARTZ | | | 2a. DATE OF DEATH MONTH DAY YEAR
12-2-83 | | 2b. HOUR 2:17 A | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
5-10-90 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
POLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | |
| 12b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | | 13a. STREET ADDRESS
67 UNDERWOOD PLACE, N. W. | | | | |
| 13b. STATE
D. C. | | 13c. CITY OR TOWN
WASHINGTON | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harry Zarnovsky Unknown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
579-12-0814 A | | 17. INFORMANT
ADDRESS
DANIEL STRICHARTZ, 67 UNDERWOOD PLACE, N. W. WASHINGTON, D. C. | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

4360

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Cerebral Vascular Accident

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF FITTER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **12/1**, 19 **78**, to **12/2**, 19 **83**, that (I) (we) lost
saw the deceased alive on **12/1**, 19 **83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

ATTENDING MEDICAL STAFF
PHYSICIAN ☒ DIRECTOR ☐ PHYSICIAN ☐

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN
PRINCE GEORGE'S, MARYLAND

24. FUNERAL DIRECTOR

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C.

DEC 07 1983
John J. Connel

RECEIVED
JAN 10 1911

Handwritten notes and signatures at the top of the page, including a signature that appears to be "J. H. [illegible]".

100% COTTON
WELLS



DEC 1 1910
J. H. [illegible]
[illegible]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|--|---|-----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) LAURA E. STUTZ | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-26-83 | | 2b. HOUR
10:15 PM | | |
| 3. SEX
FEMALE | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 25 1883 | | 6. AGE (IN YEARS LAST BIRTHDAY)
100 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ALTHEA WOODLAND | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
GOVT CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Government | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Maryland | | | | 13c. CITY OR TOWN
Montgomery | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HENRY GORDON EDMONDS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
AMANDA Maria | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(YES, GIVE WAR OR DATES)
WW I | | 17. INFORMANT
ADDRESS
Willis S. Holland, same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST.
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) VENTRICULAR FIBRILLATION
DUE TO, OR AS A CONSEQUENCE OF
(c) CORONARY ARTERY OCCLUSION | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 MINUTES
5 MINUTES
1-2 HRS. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
CHRONIC MENTAL DEPRESSION 20 YEARS | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/16 , 19 62 , to 12/26 , 19 83 , that (I) <input checked="" type="checkbox"/> well saw the deceased alive on 12/26 , 19 83 , and that in <input checked="" type="checkbox"/> my <input type="checkbox"/> our opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> I <input type="checkbox"/> we did <input type="checkbox"/> did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
James A. Roberts M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
12/26/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAMES A. ROBERTS | | | | 22e. ADDRESS
8907 GEORGIA AVE. SILVER SPRING, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(S) Burial | | 23b. DATE
Dec. 29, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Bethel Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | | | 25a. DATE RECEIVED BY REGISTRAR
JAN 3 1984 | | | |

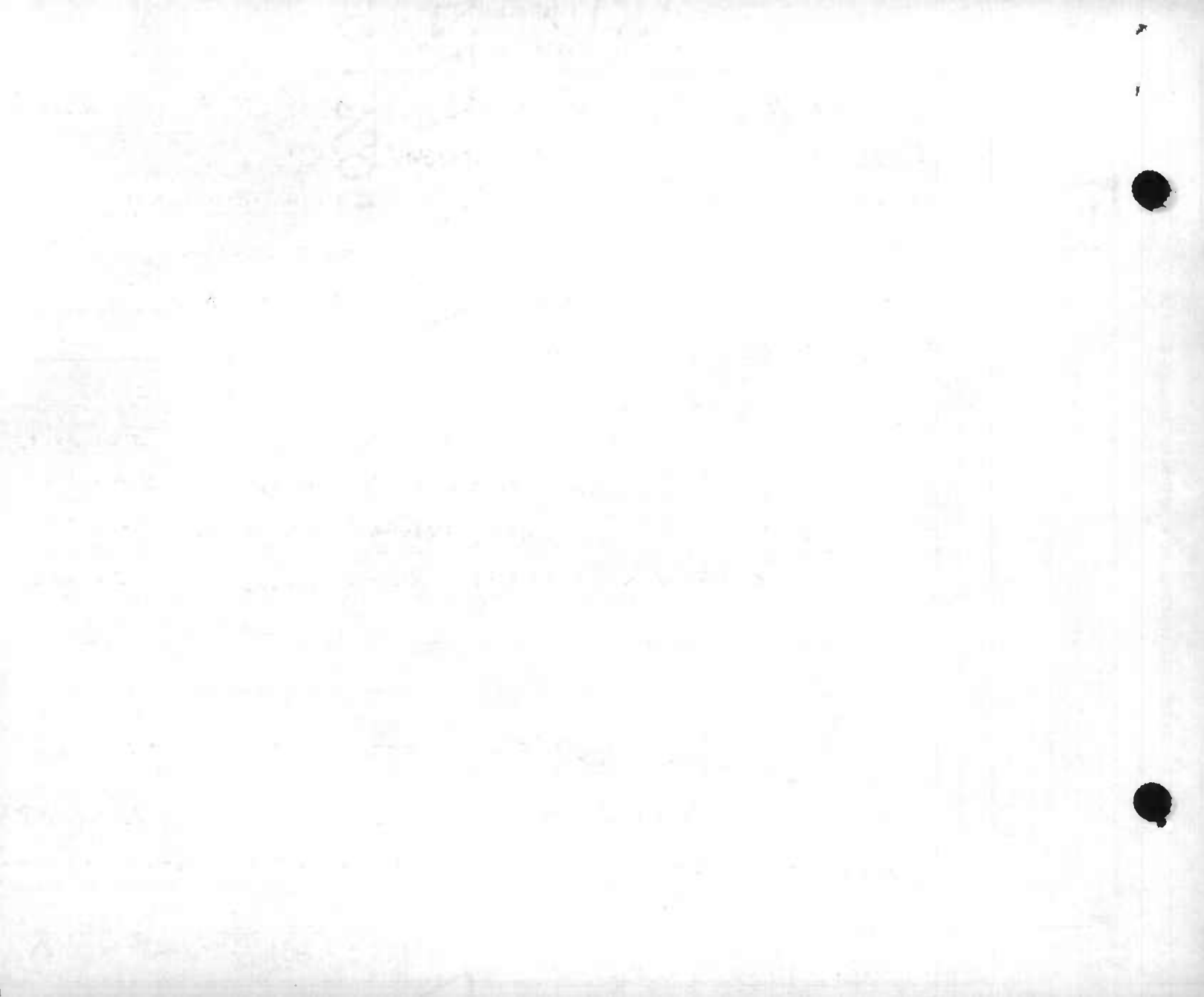
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|--------------|--|-------------------|--|-----------|--------------------------------|-------------------|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
CATHERINE | MIDDLE
M. | LAST
SULLIVAN | 2a. DATE OF DEATH | MONTH
12 | DAY
14 | YEAR
83 | 2b. HOUR
0534M |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
JAN. 30, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
GAITHERSBURG | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BOOKBINDER | | 12b. KIND OF BUSINESS OR INDUSTRY
PUBLICATIONS | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
920 CRAWFORD DRIVE (20851) | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE - VEISE | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BESSIE - BURKE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
NONE | | 17. INFORMANT
CLARE SULLIVAN (DAUGHTER-IN-LAW) | | ADDRESS
SAME AS #13. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 2028 Lymphoma -
DUE TO, OR AS A CONSEQUENCE OF
(b) pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3-4 mos
1 mb | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Coma, Bone fracture, adenoma | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 19 78 to 12-14 83, that (I) (we) lost
saw the deceased alive on 12-13 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
John S. Said MD | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/14/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John S. Said MD | | | | 22e. ADDRESS
809 Viers Mill Rd Rock MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
DEC/16/83 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SUITLAND, PGCO. MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR
NAME
CHAMBERS FUNERAL HOME SILVER SPRING, MD | | | | ADDRESS
DEC 16 1983 | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
John J. Carver | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|-----|--|---|--|------------------|--|--|--|--|--|---------------------|--|--|--|-------|--|--|--|------|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH | | | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | | | | | | | | | | | | | |
| Claude A. Swanson | | | | 12 | | | | 10 | | 83 | | 4:29p _M | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | 4. RACE | | | | 5. DATE OF BIRTH | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | IF UNDER 1 YEAR | | | | IF UNDER 24 HRS | | | | | | | | | | | |
| Male | | | | Caucasian | | | | 04 27 11 | | | | 72 years | | | | MONTHS | | | | DAYS | | | | HOURS | | | | MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | |
| Virginia | | | | U.S.A. | | | | | | | | Montgomery County MD. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| Silver Spring | | | | Holy Cross Hospital | | | | Estimator Planner | | | | U.S. GOV'T. | | | | | | | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | | | | | | | | | |
| Maryland | | | | Montgomery | | | | Wheaton | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 2666 Cory Terrace | | | | 20902 | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | | | | | | | | | |
| William K. Swanson | | | | Clara L. Williams | | | | No | | | | 578-01-5017 | | | | Elvira F. Swanson Wife | | | | Same as 13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | 2 hs. | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute cardiorespiratory arrest(failure) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4920 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) Chronic obstructive pulmonary disease | | | | | | | | | | | | | | | | 10 years (plus | | | | | | | | | | | | | | | |
| (c) Emphysema | | | | | | | | | | | | | | | | 15 years | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| -0- | | | | -0- | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | P.M. N/A 19 | | | | N/A | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | | | | | | | | | | | | | | | |
| WHILE <input type="checkbox"/> None <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 15, 19 80, to December 10, 19 83, that (I) (we) last saw the deceased alive on December 9, 19 83, and that in (my) (XX) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | |
| John P. Nasou, MD | | | | | | | | | | | | | | 12-10-83 | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | |
| John P. Nasou, MD | | | | | | | | | | | | 800 Pershing Dr. Silver Spring, MD 20910 | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | | | | | | | | | | | | | |
| Burial | | | | Dec. 14, 1983 | | | | Gate of Heaven Cemetery | | | | Silver Spring Mont. Md. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| Francis J. Collins | | | | | | | | | | | | DEC 15 1983 | | | | John J. Collins | | | | | | | | | | | | | | | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filled within 72 hours after death. Page 3 should be filled within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filled within 72 hours after death. Page 3 should be filled within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death. Page 3 should be filled within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filled within 72 hours after death. Page 3 should be filled within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | |
|---|---|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Gilfred A. Swartz</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>12-19-83</i> | | | 2b. HOUR
<i>10:05</i> ^A _M | |
| 3. SEX
<i>Male</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>11-05-07</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>76</i> YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<i>Virginia</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Holy Cross Hospital</i> | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Service Manager</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Motor Co.</i> | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | 13c. CITY OR TOWN
<i>Silver Spring</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>213 Indian Spring Drive 20901</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Henry P. Swartz</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Virginia Dillon</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>225-10-1504</i> | | 17. INFORMANT
ADDRESS
<i>Emma B. Swartz Wife Same as 13</i> | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4360

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11(a)

NOTED: Cornea of the Prostate

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/4/83</i> , 19____, to _____, 19____, that (I) (we) last
saw the deceased alive on <i>12-19-</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Robert Kratter</i> | | 22c. DATE SIGNED
<i>12/19/83</i> | | | | 22d. ADDRESS
<i>10313 Georgia Ave SILSB.</i> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>ROBERT KRATTER</i> | | 22f. ADDRESS | | | | | |

| | | | |
|---|-----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | 23b. DATE
<i>Dec. 22, 1983</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Hillcrest Cemetery</i> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Louisa Louisa Virginia</i> |
| 24. FUNERAL DIRECTOR
NAME
<i>Francis J. Collins</i> | | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 23 1983</i> |
| 500 University Blvd., W. Silver Spring, Md. | | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Connel</i> |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|---|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) James Everett Sweeney Jr. | | | | 2a. DATE OF DEATH MONTH 12 DAY 27 YEAR 83 | | 2b. HOUR 2:05 A.M. | |
| 3. SEX Male | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH May DAY 14 YEAR 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? United States | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Deliveryman | | 12b. KIND OF BUSINESS OR INDUSTRY Dairy | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE Maryland | 13b. COUNTY Montgomery | 13c. CITY OR TOWN Bethesda | 13e. STREET ADDRESS 8800 Lowell Place (20817) | | | | |
| 14. FATHER'S NAME FIRST James MIDDLE Everette LAST Sweeney | | 15. MOTHER'S MAIDEN NAME FIRST Estelle MIDDLE LAST Hall | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 579-01-3816 | | 17. INFORMANT ADDRESS D. Jeannette Sweeney, same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). IMMEDIATE CAUSE (a) Delayed Cerebral Infarcts | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks | | | |
| 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis | | | | 6 months | | | |
| (c) Generalized Arteriosclerosis | | | | 17 years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (1) Pneumonia (2) Chronic Instructive Pulmonary Disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 12/26 , 19 83 , to 12/27 , 19 83 , that (1) <input checked="" type="checkbox"/> saw the deceased alive on 12/26 , 19 83 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (1) <input type="checkbox"/> did not view the body after death. | | | | | | | |
| 22b. SIGNATURE J. Blaine Fitzgerald DEGREE M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/27/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald, M.D. | | | | 22e. ADDRESS 8218 Wisconsin Avenue Bethesda, Maryland 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec 30, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey | | | | 25a. DATE RECEIVED BY REGISTRAR JAN 3 1984 | | 25b. REGISTRAR'S SIGNATURE J. J. Smith | |
| Homes, P.A. Bethesda, Maryland 20814 | | | | | | | |

BP _____

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

| | | | | | | | | | |
|-------|--|-------|--|-------|--|-------|--|-------|--|
| No. 1 | | No. 2 | | No. 3 | | No. 4 | | No. 5 | |
| 100 | | 100 | | 100 | | 100 | | 100 | |
| 100 | | 100 | | 100 | | 100 | | 100 | |
| 100 | | 100 | | 100 | | 100 | | 100 | |
| 100 | | 100 | | 100 | | 100 | | 100 | |
| 100 | | 100 | | 100 | | 100 | | 100 | |
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| 100 | | 100 | | 100 | | 100 | | 100 | |
| 100 | | 100 | | 100 | | 100 | | 100 | |

May 11, 1911
The following is a list of the plants
which have been found in the
State of Texas.



CHITRELLA

20% COTTON FIBER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|---|---|---|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Zinat</u> <u>Teimourian</u> | | | | | 2a. DATE OF DEATH
MONTH <u>12</u> DAY <u>12</u> YEAR <u>83</u> | | | | |
| 3. SEX
<u>FEMALE</u> | | 4. RACE
<u>WHITE</u> | | 5. DATE OF BIRTH
MONTH <u>JULY</u> DAY <u>2</u> YEAR <u>1916</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>67</u> YRS. | | 2b. HOUR
<u>3:15</u> M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>IRAN</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery</u> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<u>Bethesda</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Suburban Hospital</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>HOUSEWIFE</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
<u>MARYLAND</u> | | 13b. COUNTY
<u>Mont</u> | | 13c. CITY OR TOWN
<u>POTOMAC</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<u>10308 IRON GATE Rd.</u> | |
| 14. FATHER'S NAME
FIRST <u>AHMAD</u> MIDDLE <u>FARZANEGAN</u> LAST <u>ZARINTAJ</u> | | | | | 15. MOTHER'S MAIDEN NAME
FIRST <u>SARTIP</u> MIDDLE <u>SARTIP</u> LAST <u>POTOMAC, MD</u> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
<u>NO</u> | | 16b. SOCIAL SECURITY NO.
<u>217-48-8415</u> | | 17. INFORMANT
<u>MICHAEL GANJEI</u> | | ADDRESS
<u>#5 CRESTVIEW CT</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
<u>4148</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>CARDIOGENIC SHOCK</u>
(c) <u>SEVERE ISCHEMIC CARDIOMYOPATHY</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>30 MIN</u>
<u>24 HRS</u>
<u>3 MONTHS</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>CEREBRAL ANOXIC DAMAGE DUE TO OUT OF HOSPITAL VENTRIC. FIBRILLATION</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/11/83</u> to <u>12/12/83</u> , that (I) (we) last saw the deceased alive on <u>12/11/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Roger Stevenson, Jr.</u> | | | | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>12/12/83</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>ROGER STEVENSON, JR.</u> | | | | | 22e. ADDRESS
<u>11125 ROCKVILLE PIKE ROCKVILLE, MD</u> | | | | |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY)
<u>BURIAL</u> | | 23b. DATE
<u>DEC 13, 1983</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>NATIONAL MEMORIAL PARK FALLS CHURCH, VA</u> | | 23d. LOCATION
CITY TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
<u>James R. [Signature]</u> | | | | | DATE REC'D BY REGISTRAR
<u>JAN 19 1984</u> | | | | |

BP _____



Female
Iran
White
AZN

July 2 1941

Housewife

Mary and Mont. Patricia
Fahrad
217-48-842 Michael Gaudet #2 Crestview Ct
Fahrad
Fahrad
10308 Iron Gate Rd.
Spartan

FILED

DOX CO



Dec 13 1981
National Weather Service
Crestview, Va

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Thomas Hubert, Noel Thomas | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 13 83 | | | 2b. HOUR
6:28 PM | | | |
| 3. SEX
m | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 7 19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Jamaica | | 7b. CITIZEN OF WHAT COUNTRY?
Jamaica | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY
None | |
| 13a. STATE
MD. | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Hyattsville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1428 Kandlewood St | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
unknown | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
n/a | | 17. INFORMANT
ADDRESS
694 Oglethorpe Street, N.E.
Clarence A. Thomas (son) Washington, DC | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4310 IMMEDIATE CAUSE (a) Intracerebral hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 days
Years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/13/83 to 12/13/83 , that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | |
| 22b. SIGNATURE
Michael L. Benoit MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
13 Dec 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS
11120 N. Ave 55, Rd 20904 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
12/20/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory, Suitland, Maryland | | 23d. LOCATION
CITY OR TOWN STATE
P.G. Co., MD | | | |
| 24. FUNERAL DIRECTOR
NAME
LATNEY's Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1984 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | | |
| 3831 Georgia Avenue, NW, Washington, DC | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | REG. NO. | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) LAURA L. Thompson | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Dec. 8, 1983 | | 2b. HOUR
3:22 AM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 15, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78
YRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | |
| 12b. KIND OF BUSINESS OR INDUSTRY
own home | | | | | | | |
| 13a. STATE
Maryland | | | | 13b. CITY OR TOWN
Wheaton | | 13c. STREET ADDRESS / ZIP CODE
3929 Havard Street 20906 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Washington Mobley | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Amanda C. Taylor | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-20-2224 | | 17. INFORMANT
ADDRESS
Larry W. Thompson-son-Centreville, Va. 22020 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
4100
DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hours
10 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a
Diabetes Mellitus | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Dec 7 19 83 , to Dec 8 19 83 , that (1) (we) lost saw the deceased alive on Dec 7 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Michael R. Doherty | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Dec 8 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael R. Doherty M.D. | | 22e. ADDRESS
13975 Conn ave. Silver Spring Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Dec. 10, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Montgomery Md. | |
| 24. FUNERAL DIRECTOR
Hines-Rinaldi Funeral Home | | | | 11800 N.H. Ave.,
Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
DEC 13 1983 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
John J. Canfield | |

BP

LIBRARY
OF THE
UNITED STATES
DEPARTMENT OF
AGRICULTURE
WASHINGTON, D. C.

[Faint, mostly illegible text and markings covering the page, possibly bleed-through from the reverse side. Some faint words like "LIBRARY" and "UNITED STATES" are visible at the top.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (1))
15M 2/80

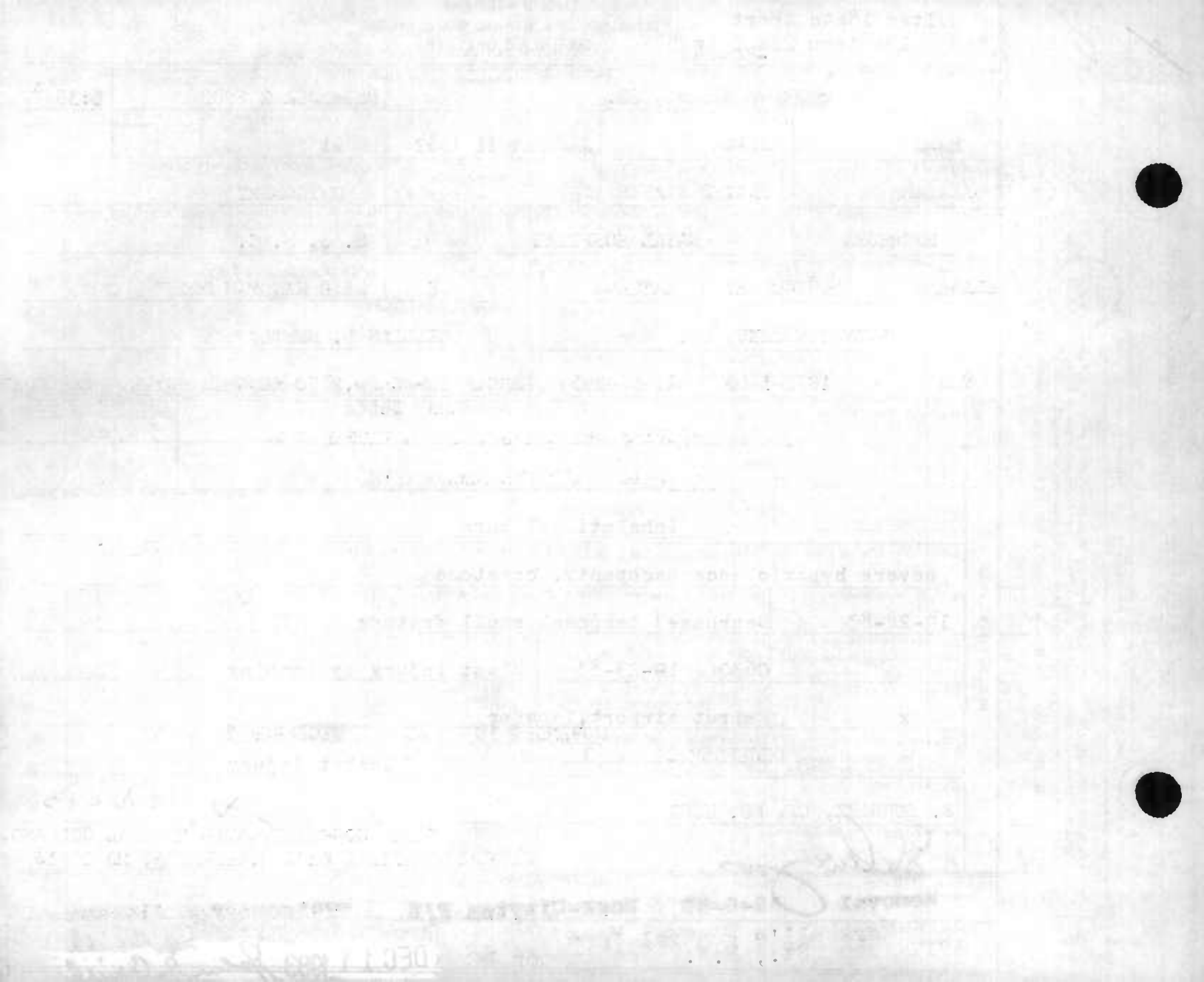
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|----------------------|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Champe B. THORNTON | | | | | | | | | | 20. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR Dec. 3rd 1983 | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH (MONTH DAY YEAR) July 11, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 21. DATE PRONOUNCED DEAD December 3, 1983 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia. | | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery | |
| 10. CITY OR TOWN OF DEATH SilverSpring | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital, SilverSpring | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR INDUSTRY) Real Estate Business owner. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Kensington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 10107 E. Bexhill Rd | |
| 14. FATHER'S NAME Champe B. Thornton the 3rd. | | | | | | 15. MOTHER'S MAIDEN NAME Margaret Chewning. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE OR UNKNOWN) NO. | | | | 16b. SOCIAL SECURITY NO. 578-05-7952 | | 17. INFORMANT A. Margaret E. Thornton ADDRESS 13 e. Wife. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial Inf.
4291
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) Chronic myocardial Inf.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
None | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY - HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE John J. Cawley | | | | | | TITLE (SPECIFY) M.D. Dep. | | | MEDICAL EXAMINER | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | ADDRESS | | | DATE SIGNED Dec 3 1983 | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial. | | | | 23b. DATE Dec. 7, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn, | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montg. Md. | | |
| 24. FUNERAL DIRECTOR Takoma Funeral Home Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 07 1983 | | | 25b. REGISTRAR'S SIGNATURE John J. Cawley | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1 shows any injury, or other traumatic event, the medical examiner must be notified in person.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|--|
| 1. FOR ITEM 18a & c & part 2
1- STATE REGISTRAR 19a thru 22a film 587
1-30-84 | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
HENRY TOWNSEND, JR. | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 2 1983 | | | 2b. HOUR
6:30 a.m. | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
JANUARY 11 1962 | | 6. AGE (IN YEARS LAST BIRTHDAY)
21 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ALABAMA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
U. S. M. C. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
ALABAMA | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
MATHEWS | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2850 KINGMAN DRIVE 99999 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HENRY TOWNSEND, SR. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LILLIAN L. HUNTER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
1979-1983 418-98-2559 | | 17. INFORMANT
ADDRESS
MARCIA TOWNSEND, 2850 KINGMAN DRIVE, PIKE ROAD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST, INHALATIONAL BURN
DUE TO, OR AS A CONSEQUENCE OF
(b) TOXIC EPIDERMAL NECROLYSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) Inhalational burn | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 weeks | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
severe hypoxic encephalopathy, comatose | | | | | | | | | |
| 19a. DATE OF OPERATION
10-28-83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Depressed temporal skull fracture | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
0630 P.M. 10-23-83 19 | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
0630 P.M. 10-23-83 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)
Blast injury by bombing | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
Beirut airport, Lebanon | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Montgomery Alabama | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 18, 1983 to DECEMBER 2, 1983 , that (I) (we) last saw the deceased alive on DECEMBER 2, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Combat injury | | | | | | | | | |
| 22b. SIGNATURE
S. SCHWARZ, LT, MC, USNR | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
2 DEC 83 | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)
S. Schwarz | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 3b. DATE
12-6-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Ross-Clayton F/H | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Montgomery Alabama | | | |
| 24. FUNERAL DIRECTOR
4217 9th St., N.W. Washington DC | | | | 25. DATE REC'D. BY REGISTRAR
DEC 12 1983 REGISTRAR'S SIGNATURE
John J. Conner | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | REG. NO. | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Ernest J. Trotier | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-12-83 | | 2b. HOUR
3.30 PM | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov 8. 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GERMANY | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MAITRE D. | | 12b. KIND OF BUSINESS OR INDUSTRY
HOTEL | |
| 13a. STATE
D.C. | | 13b. COUNTY
- | | 13c. CITY OR TOWN
WASHINGTON | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
5315 42nd PLACE NW | | 13f. CITY OR TOWN
WASHINGTON | | 13g. STATE
D.C. | | 13h. ZIP CODE
20015 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
NOT AVAILABLE TROTIER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
NOT AVAILABLE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
578-10-1685 | | 17. INFORMANT
ADDRESS
HELEN M. NORRIS, 14109 CANTERBURY LANE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
5715 IMMEDIATE CAUSE (a) Hepatic Coma
DUE TO, OR AS A CONSEQUENCE OF
(b) Cirrhosis of liver.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from August 19 74 , to 12-12, 19 83 , that (I) lost saw the deceased alive on 12-12 19 83 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death. | | | | | | | |
| 22b. SIGNATURE
John Tauber M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
12-12-83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John Tauber | | | | 22e. ADDRESS
8218 WISCONSIN AVE Bethesda Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec 16, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Md. | |
| 24. FUNERAL DIRECTOR
NAME
Takara Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1983 | | | |
| 25b. REGISTRAR'S SIGNATURE
John J. Canine | | | | | | | |

RECEIVED
JAN 10 1955
U.S. DEPT. OF AGRICULTURE

NAME: WHITE
ADDRESS: 1111 1st St.
CITY: WASHINGTON, D.C.
STATE: DISTRICT OF COLUMBIA
ZIP: 20540
DATE: 1/10/55
TIME: 10:10 AM
BY: [Signature]

RECEIVED
JAN 10 1955
U.S. DEPT. OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.
20540



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 3 3 3 3 7 2
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MAE E TYLER | | | 2a. DATE OF DEATH
MONTH 12 - DAY 2 - YEAR 83 | | | 2b. HOUR
11:40 P.M. | | | | | | |
| 3 SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH AUG. DAY 31 YEAR 15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington DC | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | | 12b. KIND OF BUSINESS OR INDUSTRY
Plumbing Co. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Burtonsville | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
15304 Blackburn Rd. 20866 | | | | | | |
| 14. FATHER'S NAME
FIRST Thomas MIDDLE Rufuss LAST Nalley | | | | 15. MOTHER'S MAIDEN NAME
FIRST Nellie MIDDLE LAST Clay | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No. | | | | 16b. SOCIAL SECURITY NO.
577-05-9626 | | 17. INFORMANT
Richard B. Tyler | | | | ADDRESS
same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
4148
DUE TO, OR AS A CONSEQUENCE OF:
Conditions, if any, which gave rise to immediate cause: (a), stating the underlying cause lost } (b) Arrhythmia
DUE TO, OR AS A CONSEQUENCE OF: (c) Myocardial Infarct | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Brain Failure, Decompensation of Liver | | | | | | | | | | | | |
| 19a. DATE OF OPERATION:
11/28/83 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Neuro | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
 | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
 | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
 | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/4/83 19 83 to 12/2/83 19 , that (I) (we) last saw the deceased alive on 12/2/83 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
H. L. MArTER | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
12/3/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
H. L. MArTER | | | 22e. ADDRESS
831 University Blvd East | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
12/6/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood P.G. Co. Md. | | | | |
| 24. FUNERAL DIRECTOR
FLECK FUNERAL HOME, INC.
7601 Sandy Spring Rd. Laurel, Md. 20707 | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 8 - 1983 REGISTRAR'S SIGNATURE
John J. Conner | | | | | | |

BP

101

| TO | | FROM | | SUBJECT | |
|-----|-----|------|------|---------|------|
| 1 | 2 | 3 | 4 | 5 | 6 |
| 7 | 8 | 9 | 10 | 11 | 12 |
| 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 |
| 25 | 26 | 27 | 28 | 29 | 30 |
| 31 | 32 | 33 | 34 | 35 | 36 |
| 37 | 38 | 39 | 40 | 41 | 42 |
| 43 | 44 | 45 | 46 | 47 | 48 |
| 49 | 50 | 51 | 52 | 53 | 54 |
| 55 | 56 | 57 | 58 | 59 | 60 |
| 61 | 62 | 63 | 64 | 65 | 66 |
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| 73 | 74 | 75 | 76 | 77 | 78 |
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| 91 | 92 | 93 | 94 | 95 | 96 |
| 97 | 98 | 99 | 100 | 101 | 102 |
| 103 | 104 | 105 | 106 | 107 | 108 |
| 109 | 110 | 111 | 112 | 113 | 114 |
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| 331 | 332 | 333 | 334 | 335 | 336 |
| 337 | 338 | 339 | 340 | 341 | 342 |
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| 547 | 548 | 549 | 550 | 551 | 552 |
| 553 | 554 | 555 | 556 | 557 | 558 |
| 559 | 560 | 561 | 562 | 563 | 564 |
| 565 | 566 | 567 | 568 | 569 | 570 |
| 571 | 572 | 573 | 574 | 575 | 576 |
| 577 | 578 | 579 | 580 | 581 | 582 |
| 583 | 584 | 585 | 586 | 587 | 588 |
| 589 | 590 | 591 | 592 | 593 | 594 |
| 595 | 596 | 597 | 598 | 599 | 600 |
| 601 | 602 | 603 | 604 | 605 | 606 |
| 607 | 608 | 609 | 610 | 611 | 612 |
| 613 | 614 | 615 | 616 | 617 | 618 |
| 619 | 620 | 621 | 622 | 623 | 624 |
| 625 | 626 | 627 | 628 | 629 | 630 |
| 631 | 632 | 633 | 634 | 635 | 636 |
| 637 | 638 | 639 | 640 | 641 | 642 |
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| 661 | 662 | 663 | 664 | 665 | 666 |
| 667 | 668 | 669 | 670 | 671 | 672 |
| 673 | 674 | 675 | 676 | 677 | 678 |
| 679 | 680 | 681 | 682 | 683 | 684 |
| 685 | 686 | 687 | 688 | 689 | 690 |
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| 697 | 698 | 699 | 700 | 701 | 702 |
| 703 | 704 | 705 | 706 | 707 | 708 |
| 709 | 710 | 711 | 712 | 713 | 714 |
| 715 | 716 | 717 | 718 | 719 | 720 |
| 721 | 722 | 723 | 724 | 725 | 726 |
| 727 | 728 | 729 | 730 | 731 | 732 |
| 733 | 734 | 735 | 736 | 737 | 738 |
| 739 | 740 | 741 | 742 | 743 | 744 |
| 745 | 746 | 747 | 748 | 749 | 750 |
| 751 | 752 | 753 | 754 | 755 | 756 |
| 757 | 758 | 759 | 760 | 761 | 762 |
| 763 | 764 | 765 | 766 | 767 | 768 |
| 769 | 770 | 771 | 772 | 773 | 774 |
| 775 | 776 | 777 | 778 | 779 | 780 |
| 781 | 782 | 783 | 784 | 785 | 786 |
| 787 | 788 | 789 | 790 | 791 | 792 |
| 793 | 794 | 795 | 796 | 797 | 798 |
| 799 | 800 | 801 | 802 | 803 | 804 |
| 805 | 806 | 807 | 808 | 809 | 810 |
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| 817 | 818 | 819 | 820 | 821 | 822 |
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| 841 | 842 | 843 | 844 | 845 | 846 |
| 847 | 848 | 849 | 850 | 851 | 852 |
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| 889 | 890 | 891 | 892 | 893 | 894 |
| 895 | 896 | 897 | 898 | 899 | 900 |
| 901 | 902 | 903 | 904 | 905 | 906 |
| 907 | 908 | 909 | 910 | 911 | 912 |
| 913 | 914 | 915 | 916 | 917 | 918 |
| 919 | 920 | 921 | 922 | 923 | 924 |
| 925 | 926 | 927 | 928 | 929 | 930 |
| 931 | 932 | 933 | 934 | 935 | 936 |
| 937 | 938 | 939 | 940 | 941 | 942 |
| 943 | 944 | 945 | 946 | 947 | 948 |
| 949 | 950 | 951 | 952 | 953 | 954 |
| 955 | 956 | 957 | 958 | 959 | 960 |
| 961 | 962 | 963 | 964 | 965 | 966 |
| 967 | 968 | 969 | 970 | 971 | 972 |
| 973 | 974 | 975 | 976 | 977 | 978 |
| 979 | 980 | 981 | 982 | 983 | 984 |
| 985 | 986 | 987 | 988 | 989 | 990 |
| 991 | 992 | 993 | 994 | 995 | 996 |
| 997 | 998 | 999 | 1000 | 1001 | 1002 |

22

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HANNAH KATHERINE ULLRICH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 18-83 | | | 2b. HOUR
2:10PM | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 14, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Lutheran Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY
Medical | |
| 13a. STATE
D.C. | | | | 13b. CITY OR TOWN
Washington | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Louis R. Ullrich | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma Lawyer | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
577-46-6456 | | 17. INFORMANT ADDRESS
Rev. Richard Reichard 9701 Veirs Dr. Rockville Md. | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BILATERAL LOWER LOBE PNEUMONIA | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____ | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 19 91 , to DEC 18 19 83 , that (I) (we) last saw the deceased alive on Dec 17 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Thomas E. Doolley, M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
12-18-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas E. Doolley, M.D. | | | | 22e. ADDRESS
9701 VEIRS ROAD
ROCKVILLE, MARYLAND 20850 | | | |

| | | | | | | | |
|---|--|-----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 20, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Centreville Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Biglerville, Pennsylvania | |
|---|--|-----------------------------------|--|---|--|--|--|

| | | | | | |
|--|--|---|--|---|--|
| 24. FUNERAL DIRECTOR
NAME
The Hysong Company 1300 N St. N.W. Washington, D.C. | | 25a. DATE REC'D. BY REGISTRAR
DEC 27 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | |
|--|--|---|--|---|--|



RECEIVED

RECEIVED

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGE 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

UNKNOWN #83-70

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|-------------------------|---|---|--|---|--|---|--|-----------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
UNKNOWN #83-70 | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
10 15 1983 | | | 2b. HOUR
M
3:15 | | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
YRS. | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
10 15 1983 | | | 2d. HOUR
a m |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Ashton | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
New Hampshire Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
999 99 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8150 IMMEDIATE CAUSE (a) Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
5:05 PM 10-15-1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Driver in van/fixed object collision. | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
New Hampshire Ave., Ashton, Montgomery, Md. | | | | |
| 22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Ann M. Dixon</i> | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 10-15-83 | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Ann M. Dixon, M.D. | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME | | | ADDRESS | | 25. DATE RECEIVED BY REGISTRAR | | 26. REGISTRAR'S SIGNATURE
<i>James J. Givens</i> | | |

RECEIVED

NOV 20 1964



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) OTTO ERNEST VAN DER AUE | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 12 DAY 30 YEAR 1983 | | 2b. HOUR A |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH
MONTH 4 DAY 27 YEAR 08 | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | IF UNDER 1 YR. MONTHS 0 DAYS 0 | IF UNDER 24 HRS. HOURS 0 MIN. 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IL | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD. |
| 10. CITY OR TOWN OF DEATH BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5305 BROOKWAY DR | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHYSICIAN | |
| 13a. STATE MD. | | 13b. COUNTY MONTGOMERY | 13c. CITY OR TOWN BETHESDA | 13d. STREET ADDRESS 5305 BROOKWAY DR | |
| 14. FATHER'S NAME
FIRST Fred MIDDLE Van Der Aue LAST Bessie | | | 15. MOTHER'S MAIDEN NAME
FIRST Bessie MIDDLE Vanrosek LAST Southport, Conn. | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) Yes. | | 16b. SOCIAL SECURITY NO. 579-52-8032 | | 17. INFORMANT George L. Van Der Aue ADDRESS 06490 Southport, Conn. 762 Mill Hill Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 4100
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DIS.
DUE TO, OR AS A CONSEQUENCE OF
(c) IN DET | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
MULTIPLE GASTROINTESTINAL PROBLEMS | | | | | |
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR A P.M. 12 30 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) COLLAPSED ON FLOOR | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME | | 21f. LOCATION
STREET 5305 BROOKWAY DR CITY OR TOWN BETHESDA COUNTY MONTGOMERY STATE MD | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE Francis C. Mayhew | | TITLE (SPECIFY) Dept. | | DATE SIGNED 12/31/83 | |
| EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayhew | | ADDRESS 8200 Wisconsin Ave Bethesda MD | | 23b. REGISTRAR'S SIGNATURE John J. Conish | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/5/84 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem. | |
| 23d. LOCATION
CITY OR TOWN Arlington, VA COUNTY VA STATE VA | | 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. | | 25a. DATE REC'D BY REGISTRAR JAN 6 1984 | |
| NAME 5130 Wisc. Ave. N.W. Wash., DC | | ADDRESS | | 25b. REGISTRAR'S SIGNATURE | |

BP

TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]

On [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Nicholas - VARGAS | | | 2a. DATE OF DEATH MONTH DAY YEAR
Dec. 18/83 | | | 2b. HOUR
6:00 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 13, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Bolivia | | 7b. CITIZEN OF WHAT COUNTRY?
BOLIVIA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SYLAN MANOR NURSING HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ADMINISTRATOR | | 12b. KIND OF BUSINESS OR INDUSTRY
MINING | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
TAKOMA PARK | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
VICTOR - VARGAS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MAXIMA - GARZON | | 13e. STREET ADDRESS
910 LARCH AVE. (20912) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
579-02-5052 | | 17. INFORMANT
ADDRESS
JAHIEL RIDGELL (DAUGHTER) SAME AS #13. | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1629

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (the hospital) attended the deceased from Dec. 2, 1983 , to Dec. 18, 1983 , that (I/we) lost
saw the deceased alive on Dec. 18, 1983 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above. (If not, do not view the body after death.) | | | | | | | |
| 22b. SIGNATURE
Glorinda M.D. | | DEGREE | | ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/18/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jorge H. FORCADA | | 22e. ADDRESS
1106 Spring St. Silver Spring | | | | | |

| | | | | | | | |
|---|--|-------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
Dec/21/83 | | 23c. NAME OF CEMETERY OR CREMATORY
FORT LINCOLN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood P.G. Co. MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
CHAMBERS FUNERAL HOME RIVERDALE, MD. | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 22 1983 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. Givens | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

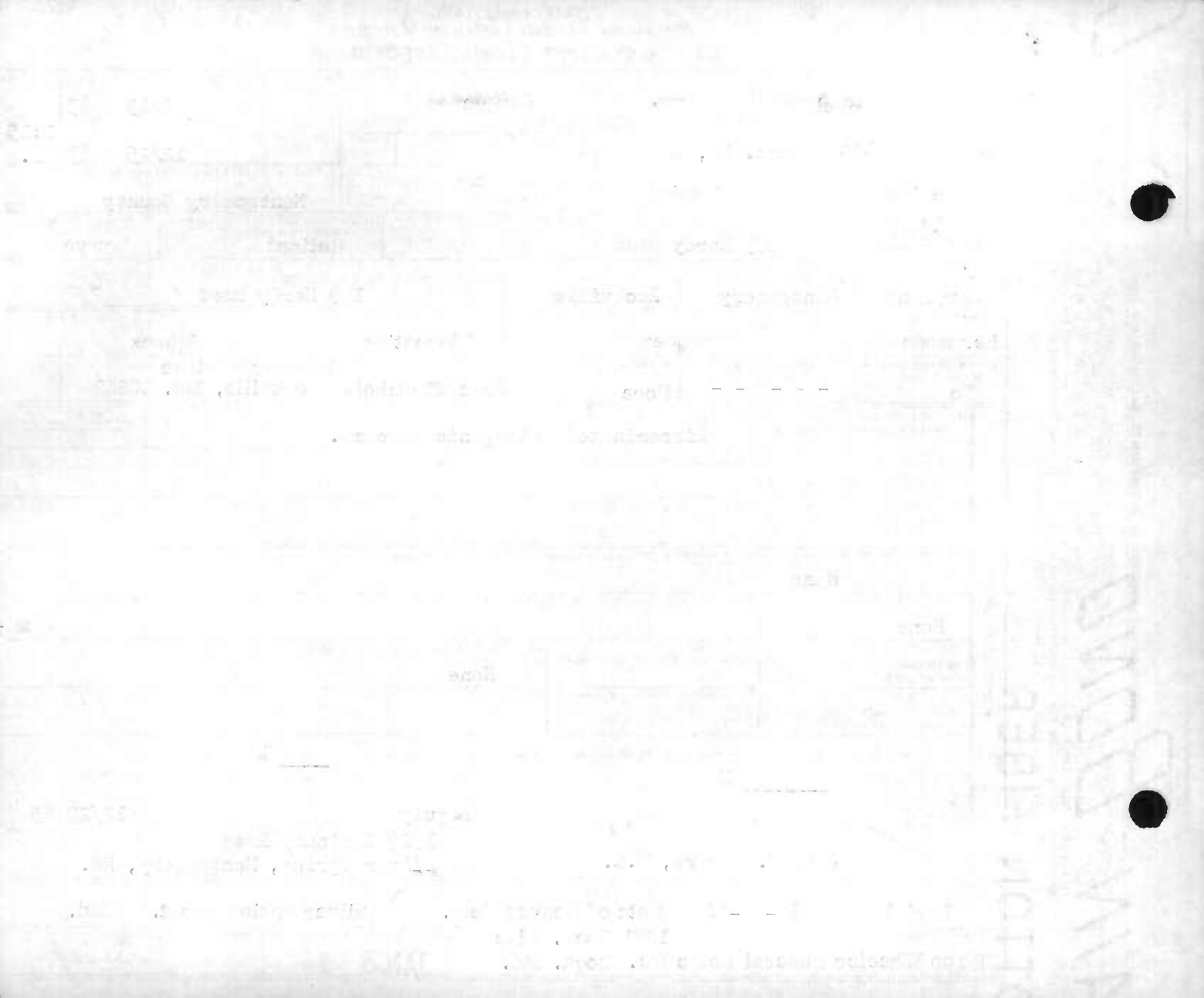


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|-------------------------|---|---|--|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Rafael Vazquez-Munoz | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
12/25 19 83 | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 24, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN | | 2b. HOUR
1:15 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mexico | | | 7b. CITIZEN OF WHAT COUNTRY?
Mexico | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
199 Hardy Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY
Lawyer | |
| 13a. STATE
Maryland | | | | | | | | | | 13b. CITY OR TOWN
Montgomery | |
| 13c. CITY OR TOWN
Rockville | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
199 Hardy Road | | | | | | | | | | 20852 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Fernando Vazquez | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florentina Munoz | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | | | | | | | 16b. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Jose Canchola | | | | | | | | | | 199 Hardy Place
Rockville, Md. 20852 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Disseminated osteogenic sarcoma.
1991
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
None | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)
None | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John S. Rogers</i> M.D. | | | | | | TITLE (SPECIFY)
Deputy | | | DATE SIGNED
12/27/83 | | |
| EXAMINER'S NAME
(TYPE OR PRINT) John S. Rogers, M.D. | | | | | | ADDRESS
1919 Seminary Road
Silver Spring, Montgomery, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
12-28-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cem. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Mont. Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Tyson Wheeler Funeral Home Inc. Rock. Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 3 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Connel</i> | | | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE GIVEN TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND; 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|-----------------|---|--|---|--|---|----------------|--------------------------------|--|--|--|---|---|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
GEORGE | | | MIDDLE
J | | | LAST
VERNON | | | 2a. DATE OF DEATH
KNOWN ESTIMATED
<input checked="" type="checkbox"/> 12 16 1983 | | | 2b. HOUR
203A | | | | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
02 15 15 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
68 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
12 16 1983 | | | 2d. HOUR
203A | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
SERVICE MAN | | | | 12b. KIND OF BUSINESS OR INDUSTRY
WASH. GAS CO | | | | | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND | | | | | | | | | | | | 13b. CITY OR TOWN
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1122 CADDINGTON AVENUE 20901 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM HENRY VERNON | | | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ROSE BIGGS | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
YES | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | | | 17. INFORMANT
IRENE VERNON (WIFE) | | | | ADDRESS
1122 CADDINGTON AVE. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Reptured Abdominal</u>
4413 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. }
(b) <u>Acute Aneurysm</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>None</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>None</u> | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<u>John Rogers</u> | | | | | | | | | | | | TITLE (SPECIFY)
M.D. Dep. | | | MEDICAL EXAMINER | | | DATE SIGNED
Dec 16 1983 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
DR JOHN ROGERS | | | | | | | | | | | | ADDRESS
1919 SEMINARY RD SILVER SPRING MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
DEC. 19, 1983 | | | | 23c. NAME OF CEMETERY OR CREMATORY
FT. LINCOLN CEMETERY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BRENTWOOD PR. GEO. MD. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 23 1983 | | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Carver</u> | | | | | | | | |
| 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. | | | | | | | | | | | | | | | | | | | | | | | |

3319701

1

2

3

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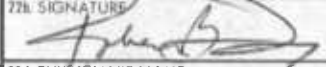

5

6



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Viola Louise Vincent | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-8-83 | | | 2b. HOUR
4.46^P | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 24 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Conn. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
own home | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10709 Kinock Road, 20903 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Simmons | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lena Rowe | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
N/A | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
N/A | | 17. INFORMANT ADDRESS
Walter T. Vincent-son- (same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure.
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____ | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March , 19 80 , to Dec. 8 , 19 83 , that (I/we) last saw the deceased alive on Dec. 8 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) saw the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
 | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Dec. 8, 1983 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert Irey, MD | | | 22e. ADDRESS
11161 New Hampshire Ave., Silver Spring, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
Dec. 9, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi Funeral Home | | | 11800 N.H. Ave.,
Silver Spring, Md. | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
 | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examinations should be deferred for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified of cause.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|---|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Harry M. Wallace Jr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
12-24-83 | | | 2b. HOUR
5:39 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Sept. 24, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Purchasing Agent | | 12b. KIND OF BUSINESS OR INDUSTRY
Electronics Mfg. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
605 W. Edmonston Dr. 20852 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Harry M. Wallace Sr. | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Celeste C. Ogle | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WW II | | | | | 16b. SOCIAL SECURITY NO.
174-01-3961 | | 17. INFORMANT ADDRESS
Mrs. Mary L. Wallace 605 W. Edmonston Dr. Rockville, Md. 20852 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Pneumonia
3352
DUE TO, OR AS A CONSEQUENCE OF (b) Amyotrophic Lateral Sclerosis
4 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hrs | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 23, 1983, to Dec 24, 1983, that (I) (we) lost saw the deceased alive on Dec 24, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Eugene P. Flannery MD | | | | | DEGREE
MD | | | 22c. DATE SIGNED
12/24/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EUGENE P. FLANNERY, MD | | | | | 22e. ADDRESS
1811 PRINCE PHILIP DR. - OLNEY, MD. 20832 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/28/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Waynesboro Franklin Pa. | | | |
| 24. FUNERAL DIRECTOR
David C. ... 50 S. Broad St. ADDRESS 17268 | | | | | 25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE
DEC 29 1983 John J. ... | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|---|--|--------------------------------|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Marion R. Wallace | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 22, 1983 | | | 2b. HOUR
6:10AM | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 27, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Massachusetts | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD | | | | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bethesda Retirement & Nursing Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
Veterans Administration | | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Patrick Rooney | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julia M. Pitts | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-44-3105 | | 17. INFORMANT
ADDRESS
W. Thomas Wallace 501 Nottingham RD.
Charlottesville, VA | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis Right Hemisphere</u>
4340
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cerebral Arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Generalized Arteriosclerosis</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 Days</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Arteriosclerotic Heart Disease</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/5</u> to <u>12/22</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/21</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) | | | | | | | | | | |
| 22b. SIGNATURE
<u>J. Blaine Fitzgerald</u> | | | | 22c. DATE SIGNED
12/22/83 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. Blaine Fitzgerald, M.D. | | |
| 22e. ADDRESS
8218 Wisconsin Avenue
Bethesda, Maryland 20814 | | | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Entombment | | 23b. DATE
Dec 24, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood, Maryland | | | | |
| 24. FUNERAL DIRECTOR
NAME Robert A. Pumphrey
Homes, P.A. Bethesda, Maryland 20814 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 29 1983 | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Carver</u> | | | | |

BP

Received of the
Commissioner of the
Department of Agriculture
the sum of \$100.00
for the purchase of
land for the purpose of
establishing a
farm for the
instruction of
the deaf and
blind.

10/25 - 1/25 - 2/25 - 3/25 - 4/25 - 5/25 - 6/25 - 7/25 - 8/25 - 9/25 - 10/25 - 11/25 - 12/25

Received of the
Commissioner of the
Department of Agriculture
the sum of \$100.00
for the purchase of
land for the purpose of
establishing a
farm for the
instruction of
the deaf and
blind.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

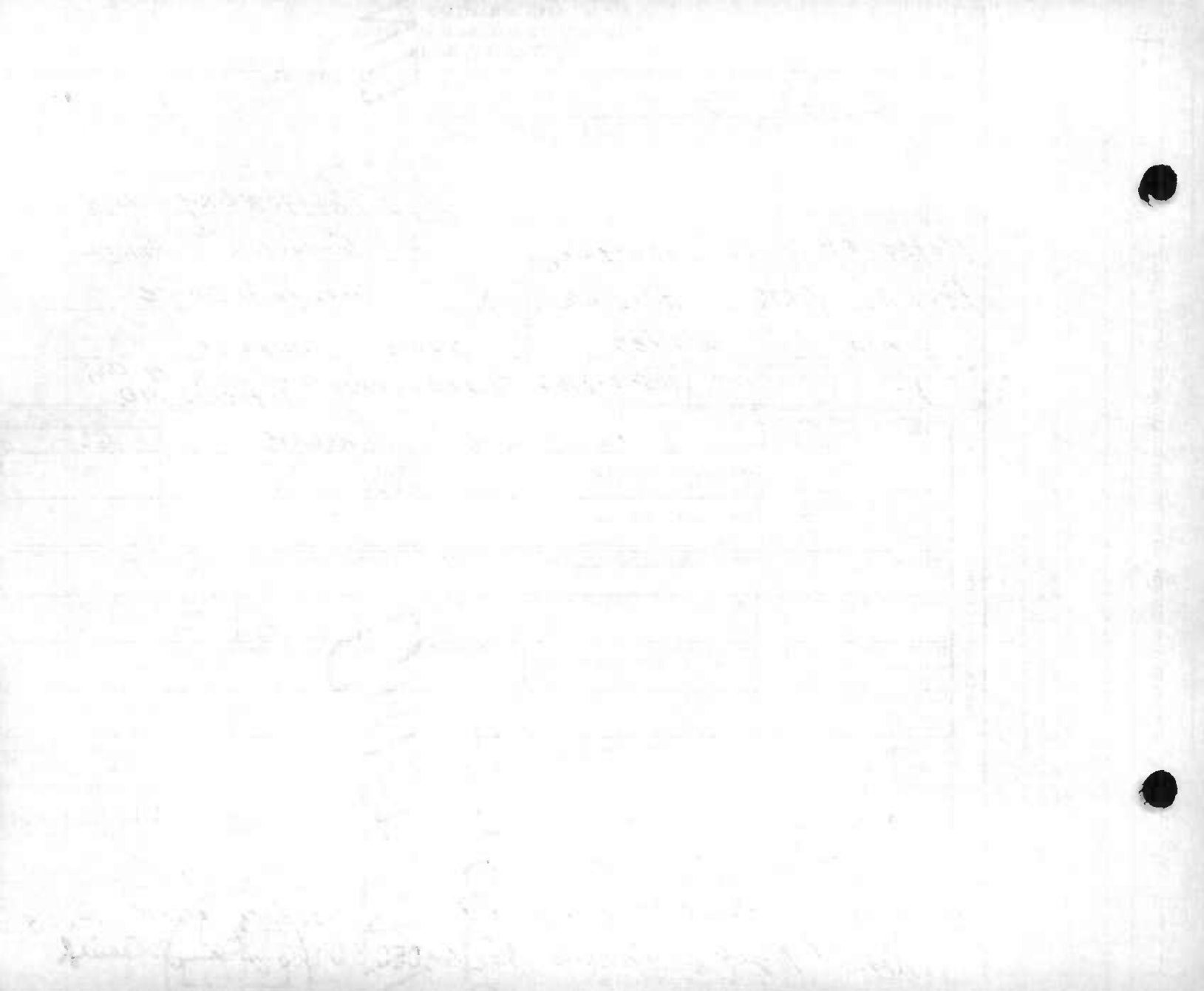
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
OLIVER OSCAR WALTER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12/26/83 | | | 2b. HOUR
9:35 M | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 21 1894 | | 6. AGE IN YEARS (LAST BIRTHDAY)
89 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
15125 Wickett Dr. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CONDUCTOR | | 12b. KIND OF BUSINESS OR INDUSTRY
Railroad | | |
| 13a. STATE
PENNA | | | 13b. COUNTY
GORK | | 13c. CITY OR TOWN
Harrover | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1032 Keith Drive 99999 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Simon Walter | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sapie Danner | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
705-10-7762 | | 17. INFORMANT
ADDRESS
JEANNE DANNER 5125 Wickett Dr.
Bethesda MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4860 congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Franke Wusthal | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/26/1983 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WEST PHAL, Franke | | | 22e. ADDRESS
809 Viers Mill Rd. Rockville | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
12-30-83 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt-Olivet | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Harrover YORK PENNA | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert Myers | | | ADDRESS
Wilmington Maryland | | | 25. DATE REC'D. BY REGISTRAR
DEC 30 1983 | | 26. REGISTRAR'S SIGNATURE
John J. Canine | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | |
|--|---------------------|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Hermypae C. Walters</i> | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
<i>Dec 12 1983</i> | | 2b. HOUR
M
<i>2:40</i> |
| 3. SEX
<i>F</i> | 4. RACE
<i>W</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>Dec 5 1928</i> | 6. AGE (IN YEARS)
LAST BIRTHDAY
YRS.
<i>55</i> | IF UNDER 1 YR.
MONTHS DAYS
<i>0 0</i> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH
<i>Olney</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Mont General Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Legal Secretary</i> |
| 13a. STATE
<i>MD</i> | | 13b. COUNTY
<i>Mont</i> | 13c. CITY OR TOWN
<i>Silver Spring</i> | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>James F. Gibbs</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Lucy Eddins</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>577-60-3113</i> | | 17. INFORMANT
<i>Daughter</i> ADDRESS
<i>6 Maxim Lane Rockville, Md. 20852</i> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarct</i>
4291
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.
<i>None</i> | | | | |
| 19a. DATE OF OPERATION
<i>None</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE
<i>John S. Rogers</i> | | TITLE (SPECIFY)
M.D. <i>Dep.</i> | | DATE
<i>Dec 12 1983</i> |
| EXAMINER'S NAME
(TYPE OR PRINT) <i>John S. Rogers, M. D.</i> | | ADDRESS <i>1919 Seminary Road Silver Spring, Md.</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <i>Burial</i> | | 23b. DATE
<i>Dec. 15, 1983</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Parklawn Cemetery</i> |
| 24. FUNERAL DIRECTOR
NAME
<i>Francis J. Collins</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Rockville Mont. Md.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 15 1983</i> |
| 25b. REGISTRAR'S SIGNATURE
<i>John J. Conner</i> | | | | |



[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

NOV 19 1958

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARTHA E. WARFIELD | | | 2a. DATE OF DEATH
MONTH 12 DAY 3 YEAR 83 | | | 2b. HOUR
7:55 ^A _M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH Aug. DAY 27 YEAR 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 | | 7. IF UNDER 1 YEAR
MONTHS YRS. DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 9. CITIZEN OF WHAT COUNTRY?
USA | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 12. CITY OR TOWN OF DEATH
Silver Spring | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 14. USUAL OCCUPATION
(TYPE OF WORK OR MOST OF WORKING LIFE)
Homemaker | | 15. KIND OF BUSINESS OR INDUSTRY
own home | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring | | 17. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 18. STREET ADDRESS
14014 Notley Road, 20904 | | | | | |
| 19. FATHER'S NAME
FIRST Francis MIDDLE K. LAST Ott | | | 20. MOTHER'S MAIDEN NAME
FIRST Anastasia MIDDLE Billman LAST Billman | | | | | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) N/A | | 22. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES) N/A | | 23. INFORMANT ADDRESS
Mrs. Elizabeth Goss-daughter-(same as 13e) | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CONGESTIVE HEART FAILURE**

4029
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **HYPERTENSIVE-ARTERIOSCLEROTIC CARDIOVASC. DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

(c) **CHRONIC OBSTRUCTIVE PULMONARY DISEASE**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|------------------------|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
|------------------------|--|--|--|--|--|--|--|

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
|--|--|--|--|---|--|--|--|

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
|--|--|--|--|---|--|--|--|

22. I certify that (I) (this hospital) attended the deceased from **JAN** 19 **80** to **Dec 3** 19 **83**, that (I) (we) lost saw the deceased alive on **Dec 2** 19 **83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE **Bernard A Fitzgerald** DEGREE **M.D.** ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED **12-3-83**

22d. PHYSICIAN'S NAME (TYPE OR PRINT) **BERNARD A. FITZGERALD** 22e. ADDRESS **217 UNIVERSITY BLVD E, SILVER SPRING, MD 20901**

| | | | | | | | |
|---|--|-------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec. 5, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | 23d. LOCATION
CITY OR TOWN Silver Spring COUNTY Montgomery STATE Md. | |
|---|--|-------------------------------|--|--|--|--|--|

24. FUNERAL DIRECTOR **Hines/Rinaldi Funeral Home** ADDRESS **11800 N.H. Ave., Silver Spring, Md.** 25. DATE REC'D. BY REGISTRAR **DEC 5 1983** 25b. REGISTRAR'S SIGNATURE **John J. Connel**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs and possibly a table or list structure.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mary <i>Mary</i> Margaret <i>Margaret</i> Warren <i>Warren</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>Dec. 8 1983</i> | | | 2b. HOUR
<i>1:24 PM</i> | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>February 12, 1887</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>96</i> | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>New York</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U S A</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Suburban Hospital</i> | | | | 12a. USUAL OCCUPATION
(WORK OR MOST IMPORTANT INDUSTRY)
<i>Chief of Interior</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Hacey Co.</i> | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Bethesda</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>John Hibner Warren</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Lillie Andrus</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <i>no</i> | | | | | |
| 16b. SOCIAL SECURITY NO.
<i>085-05-1412</i> | | 17. INFORMANT
ADDRESS
<i>2609 N. Military Rd. Arlington, Va. 22207</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Respiratory failure</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Intestinal Obstruction</i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>None</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>None</i> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <i>None</i> 19 <i>82</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
<i>None</i> | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>April 12/8 19 83</i> to <i>present</i> 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>12/8 19 83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>John B. Umhau MD</i> | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>12/8/83</i> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>John B. Umhau MD</i> | | 22e. ADDRESS
<i>8805 Conn. Ave., Chevy Chase Md.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Cremation</i> | | 23b. DATE
<i>12-11-83</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Cedar Hill Crematory</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Suitland Maryland</i> | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Joseph Gawler's Sons, Inc.</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 15 1983</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Connel</i> | | | |
| 25c. ADDRESS
<i>5130 Wisc. Av NW Wash., DC 20016</i> | | | | | | | | | |

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NOTES

REMARKS

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | | | | | |
|---|--|-------------------------|--|--|--|---|--|---|--|--|--|---|--|-------------------|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Terry Wayne Watson | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH 12 DAY 3 YEAR 1983 | | 2b. HOUR M | | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH April DAY 6 YEAR 1964 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 19 YRS. | | IF UNDER 1 YR.
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | | 7c. DATE PRONOUNCED DEAD
MONTH 12 DAY 3 YEAR 1983 | | 7d. HOUR M | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Construction | | | | | | | |
| 13a. STATE
W.Va. | | | | 13b. COUNTY
Taylor | | | | 13c. CITY OR TOWN
Four States | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS
Gen. Delivery Four States | | | |
| 14. FATHER'S NAME
FIRST Abraham MIDDLE L. LAST Watson | | | | 15. MOTHER'S MAIDEN NAME
FIRST Alta MIDDLE Lawler LAST Lawler | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
Unk. | | | | 17. INFORMANT ADDRESS
Ross Funeral Home 801 Fairmont Ave. 26554 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
9554 IMMEDIATE CAUSE (a) Gunshot wound to abdomen
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
(c) _____
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
2:30xx 12 3 1983 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
Self inflicted | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
house | | | | 21f. LOCATION
STREET 10859 Amherst Ave, CITY OR TOWN Wheaton, COUNTY Mont. STATE Md. | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion Accident <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Thomas D. Smith | | | | TITLE (SPECIFY)
Deputy Chief | | | | M.D. 12/4/83 | | | | DATE SIGNED 12/4/83 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Thomas D. Smith, M.D. | | | | ADDRESS
111 Penn St. Balto., MD. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
12-7-83 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Grove | | | | 23d. LOCATION
CITY OR TOWN Harmony Grove COUNTY Taylor STATE W.Va. | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME Mitchell-Wiedefeld Home ADDRESS 6500 York Road 21212 | | | | | | | | | | | | | | | | | | | |

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3. 1.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
John H. Werner | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 15 83 | | | 2b. HOUR
1429 ^M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 9, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Mechanical Engineer, U.S. Gov't | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Damascus | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Elizabeth Denhardt | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | |
| 16b. SOCIAL SECURITY NO.
216-44-3496 | | 17. INFORMANT
ADDRESS
Mary W. Rose, 25116 Oak Dr. Damascus, Md. 20872 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hrs
4 hrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/13</u> , 19 <u>83</u> , to <u>12/15</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12/15</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
12/15/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dennis Friedman | | 22e. ADDRESS
13-15 E. DEER PARK DR, GAITHERSBURG | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Dec. 18, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Damascus Meth. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Damascus, Montgomery, Md. | |
| 24. FUNERAL DIRECTOR
Olin L. Molesworth, P.A., Damascus, Md. | | | | 25. DATE REC'D. BY REGISTRAR
DEC 20 1983 | | 25. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

BP

10270 • J. Neurosci., July 26, 2006 • 26(30):7967–7975

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1. The first step is to identify the problem or goal.

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

• note number

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

12174

[Faint handwritten signature]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Jeymour | | FIRST MIDDLE LAST WERNER | | 2a. DATE OF DEATH MONTH DAY YEAR DEC. 2, 1983 | | 2b. HOUR 4:02 PM | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR JULY 20, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSP'T. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTORNEY + ACCOUNTANT | | 12b. KIND OF BUSINESS OR INDUSTRY POWER CORP. | |
| 13a. STATE MD. | | 13b. COUNTY MONTG. | | 13c. CITY OR TOWN SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH WERNER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHER SHULMAN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 051-14-0805 | |
| 17. INFORMANT ADDRESS SHIRLIE WERNER (SAME AS ITEM #13) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: Aspirin | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES | | | |
| IMMEDIATE CAUSE (a) 4149 | | DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease | | YEARS YEARS | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis | | Decade Decade | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) this hospital attended the deceased from 5-18 , 19 83 , to 12-2 , 19 83 , that (I) (we) lost saw the deceased alive on 11-23 , 19 83 , and that it (my (our)) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Samuel Itscowitz, MD | | DEGREE MD | | 22c. DATE SIGNED 12-2-83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL ITSCOWITZ | | 22e. ADDRESS 10313 Georgia Avenue, S.S., Md. | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE DEC. 4, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND 16C Md. | |
| 24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. | | ADDRESS 8655 GEORGIA AVE. SILVER SPRING, MD. | | 25a. DATE REC'D. BY REGISTRAR DEC 07 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Gauer | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



12th Nov 1952
[Faint, mostly illegible text follows, appearing to be a letter or report. Some words like 'Dear Sir', 'I am writing to you', and 'Yours faithfully' are faintly visible.]

W. M. CHA. 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|---|--|---|--|--|---|---|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST Wanda MIDDLE L. LAST Wheelock | | | | | 2a. DATE OF DEATH MONTH 12 DAY 13 YEAR 1983 | | | 2b. HOUR 1400 M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH Apr. DAY 30 YEAR 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY At Home | |
| 13a. STATE Md. | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Derwood | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 20855 Briardale Road | |
| 14. FATHER'S NAME FIRST James MIDDLE D. LAST Hampton | | | | 15. MOTHER'S MAIDEN NAME FIRST Dakota MIDDLE -- LAST Beason | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 302-07-0866 | | 17. INFORMANT ADDRESS Steven E. Wheelock, Same address as #13. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
4960
DUE TO, OR AS A CONSEQUENCE OF (b) upper respiratory tract infection
DUE TO, OR AS A CONSEQUENCE OF (c) Obstructive Lung Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
14 Days
28 Days
60 YR. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Kyphoscoliosis | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 28 , 19 83 , to Dec. 12 , 19 83 , that (I) (we) last saw the deceased alive on Dec. 12 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Frank J. Mayo | | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 12-12-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank J. Mayo | | | | | 22e. ADDRESS 16220 Frederick Rd. Gaithersburg, Md. 20877 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 12/17/83 | | 23c. NAME OF CEMETERY OR CREMATORY Wheelock Cem. | | 23d. LOCATION CITY OR TOWN West Milton, Ohio COUNTY STATE | | |
| 24. FUNERAL DIRECTOR NAME Gartner - Sandison Funeral Home ADDRESS 316 E. Diamond Ave. Gaithersburg, Md. 20706 DATE RECEIVED BY REGISTRAR DEC 19 1983 REGISTRAR'S SIGNATURE John J. Lohr | | | | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|------------------------|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | MONTH | | | DAY | | | YEAR | | | 2b. HOUR | | | | | |
| Mary P. Whitehead | | | 12 | | | 31 | | | 83 | | | 4:44pm | | | M | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS | | | | | |
| female | | | black | | | MONTH DAY YEAR
4 14 1888 | | | 92 | | | YRS. | | | MONTHS DAYS HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Ark. | | | USA | | | | | | Montgomery County MD | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | | | | | | | | |
| Takoma Park Md | | | Washington Adventist Hospital | | | | | | | | | | | | | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | |
| Unknown | | | Unknown | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | | | | | | |
| Maryland | | | PG | | | New Carrollton | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 6629 Chestnut Avenue 20784 | | | | | | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | |
| George Washington | | | | | | Carrie Washington | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT ADDRESS | | | | | | | | |
| No | | | | | | 362 16 08640 | | | | | | Mrs. Dorothy Evans/daughter/same as 13e | | | | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

2765

IMMEDIATE CAUSE (a) cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) dehydration

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

45 minutes

7 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

atherosclerosis

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | STREET | | | CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 31</u> , 19 <u>83</u> , to <u>Jan 2</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Dec 31</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | 22c. DATE SIGNED | | |
| <u>G. Alexander Fleming, MD</u> | | | | | | | | | Jan 2, 1984 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | |
| G. Alexander Fleming, MD | | | | | | Washington Adventist Hospital Emergency Dept
Takoma Park, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | |
| Burial | | | 1-4-84 | | | Cedar Hill | | | Suitland, County Md. STATE | | |

24. FUNERAL DIRECTOR

John T. Rhines Co., 3015 12th St. N.E., D.C. 20017

ADDRESS

JAN 10 1984 REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page # 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HIDA KOHR WILLIAMS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-10-83 | | | 2b. HOUR
3:35 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
CAUC. | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 6 90 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASH. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
CHEVY CHASE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BETHESDA RETIREMENT + NSG. CENTER | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK PERFORMED OR WORKING LIFE)
Retired Accountant | |
| 13a. STATE
MD. | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
CHEVY CHASE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Harvey A. Kohr | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lucy G. Ramsay | | 16. STREET ADDRESS
3724 MANOR RD. 20815 | | 17. INFORMANT
Rockville, Md. 20852
Louis Williams III 11912 Renwood Lane | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 18b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216 46 1534 | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 19c. DATE OF OPERATION | | 19d. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 21e. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21f. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21g. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 21h. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from
the date of death until (the date) view the body after death | | 22b. I certify that (1) (this hospital) attended the deceased from
the date of death until (the date) view the body after death | | 22c. I certify that (1) (this hospital) attended the deceased from
the date of death until (the date) view the body after death | | 22d. I certify that (1) (this hospital) attended the deceased from
the date of death until (the date) view the body after death | |
| 22e. SIGNATURE
J. Blaine Fitzgerald | | 22f. PHYSICIAN'S NAME (TYPE OR PRINT)
J. Blaine Fitzgerald | | 22g. ADDRESS
8218 Wisconsin Ave. Bethesda, Md. 20014 | | 22h. DATE SIGNED
12/10/83 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
12/13/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION
Suitland, Maryland STATE | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Md. 20852 | | 25a. DATE REC'D. BY REGISTRAR
DEC 16 1983 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | | 25c. REGISTRAR'S SIGNATURE | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

RECEIVED
JAN 10 1964

WASHINGTON

RECEIVED

1964

WASHINGTON, D.C.
JAN 10 1964

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WASHINGTON, D.C.

RECEIVED

RECEIVED

per phone call hospital

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR Item #16b
1 - STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOHN ALLEN WILLIAMS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 10 1983 | | | 7b. HOUR
P M
8:30 P M | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 13 1939 | | 6. AGE (IN YEARS LAST BIRTHDAY)
44 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEBRASKA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S.M.C. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
VIRGINIA | | 13b. COUNTY
PRINCE WM | | 13c. CITY OR TOWN
TRIANGLE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
18907 WHITE OAKS DRIVE 22172 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ROBERT WILLIAMS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ALVALAH LAMBERTSON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
1961-1983 505/44/2332 | | 17. INFORMANT
ADDRESS
SANDRA K. WILLIAMS 18907 WHITE OAKS DRIVE, 22172 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION AND PNEUMONIA
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 2, 1983 , to DECEMBER 10, 1983 , that (I) (we) last saw the deceased alive on DECEMBER 10, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Eugene Skellern MD</i> | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12 Dec 83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
E. KILLEAVY, LT. MC. USNR | | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
12/16/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Grove | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
DeWitt, Nebraska | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Walter J. Host
Cunningham-Mountcastle F.H. Woodbridge, Va. | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 15 1983 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Conrad</i> | | |

Item 26G589 3/2/84JAB

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARJORIE WILLIAMS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12-28-1983 | | | 2b. HOUR
11 35 AM | | | | |
| 3. SEX
FEMALE | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
10-12-1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
IOWA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Sandy Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Friends Nursing Home | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sandy Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
17401 Norwood Rd. 20860 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
J. Edgar Williams | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna White | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
019-26-2262A | | 17. INFORMANT
17401 Norwood Rd, Sandy Spring, Md. | | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) CEREBROVASCULAR / SCHEMIA
2500
DUE TO, OR AS A CONSEQUENCE OF (b) DIABETES MELLITUS
DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C., V.D.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7-8 YRS
YRS. | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
ALZHEIMER'S DEMENTIA | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 12/27/83 to 12/28/83 , and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (I) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Donald R. Lewis MD. | | | | | | DEGREE
MD. | | 22c. DATE SIGNED
12/29/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DONALD R. LEWIS MD | | | | | | 22e. ADDRESS
OLNEY, Md 20853 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | | 23b. DATE
12/29/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Geo. Wash. Med. School | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR
NAME
Columbia Mortuary Services, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |
| 225 Missouri Ave. NW Washington, D.C. 20011 | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 above any injury, or other traumatic event, the medical examiner should be notified.

12-28-1903 11:32

Montgomery

Town

17th St. NW. 20050

and other

and other

White

Ann

Edgar Williams

J.

On 2-23-1904 17th St. NW. 20050

17th St. NW. 20050

Columbia University Press, Inc.

17th St. NW. 20050

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|--|--|--|--|--|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Michelle Renee Wilson | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 12 15 19 83 | | 2b. HOUR M 6:15P | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH
MONTH DAY YEAR Jan. 7, 1968 | | 6. AGE (IN YEARS LAST BIRTHDAY) 15 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York City | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE) Student | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY Silver Spring | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 141 Fleetwood Terrace 20910 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST DWIGHT T. WILSON | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Norma Smith | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 220 02 8938 | | 17. INFORMANT ADDRESS Dwight T. Wilson-father-141 Fleetwood Terrace, Silver Spring, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cranio cerebral trauma
8147
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR 7:38xx 12 14 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by school bus | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE Wayne Ave & Mansfield Rd, Silver Spring, Mont, Md. | | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith | | | | TITLE (SPECIFY) Deputy Chief M.D. MEDICAL EXAMINER | | | | DATE SIGNED 12/16/83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St. Balto., MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Dec. 20, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE Silver Spring, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Stewart Funeral Home ADDRESS 4001 Benning Rd., N. | | | | 25a. DATE REC'D. BY REGISTRAR DEC 23 1983 | | 25b. REGISTRAR'S SIGNATURE Joan J. Canine | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director for page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) EVA M. Windsor | | | | | 2a. DATE OF DEATH MONTH 12 DAY 1 YEAR 83 2b. HOUR 9:50 P.M. | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH 11 DAY 27 YEAR 03 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash DC | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Ignace Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY - | |
| 13a. STATE Md. | | 13b. COUNTY Pr. Geo. | | 13c. CITY OR TOWN Landover | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4013 - Cooper Lane 20784 | |
| 14. FATHER'S NAME FIRST John MIDDLE E. LAST Burroughs | | | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE (Unknown) LAST (Unknown) | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 579-16-0600 | | 17. INFORMANT ADDRESS Patricia A. Belt - 2737-Davonshire Place, N.W., Wash. D.C. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) myocardial infarction (b) coronary artery disease (c) hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. due to, or as a consequence of | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: mitral valve disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (a) this hospital attended the deceased from 3/4 19 77 to 12/1 19 83 , that (b) (we) lost 11/30 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.) | | | | | | | | | |
| 22b. SIGNATURE Dr. Lewis Dennis DEGREE M.D. | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 12/5 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS 831-University Blvd., Silver Spring, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 12/5/1983 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md. | | | |
| 24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc. ADDRESS Mt. Rainier, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 08 1983 REGISTRAR'S SIGNATURE John J. Conner | | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|-------------------------|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
WILLIAM ROBERT WINES | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
12-16-83 | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
07 23 23 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
60 YRS. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR
12-16-83 19 | | 2b. HOUR
2:35 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Potomac | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
10500 Mac Arthur Blvd. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY
PAVING CO. | |
| 13a. STATE
MARYLAND | | | | 13b. CITY OR TOWN
MONTGOMERY | | 13c. CITY OR TOWN
BROOKEVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
3737 GREGG ROAD, 20833 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JAMES ROBERT WINES | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ANNA GERTRUDE WALTON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
YES | | | | 16b. SOCIAL SECURITY NO.
WW II | | 17. INFORMANT
MADDOX FUNERAL HOME | | ADDRESS
105 W. MAIN ST. ROYAL, VA. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Multiple injuries</u>
9199
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
2:30 PM 12-16-83 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
subject caught under steam roller | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
bldg. | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
10500 Mac Arthur Blvd. Potomac, Maryland | | | | | |
| 22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Margareta A. Korell</i> | | | | TITLE (SPECIFY)
M.D. Assistant | | | | DATE SIGNED
12-17-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Margarita A. Korell, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
REMOVAL/BURIAL | | | | 23b. DATE
12-20-83 | | 23c. NAME OF CEMETERY OR CREMATORY
PROSPECT HILL | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
FRONT ROYAL WARREN VA | |
| 24. FUNERAL DIRECTOR NAME
HUBBARD FUNERAL HOME, INC. BALTO., MD. 21229 | | | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1983 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Smith</i> | | | |

MEDICAL CERTIFICATION



RECEIVED
FEB 20 1964

NOTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

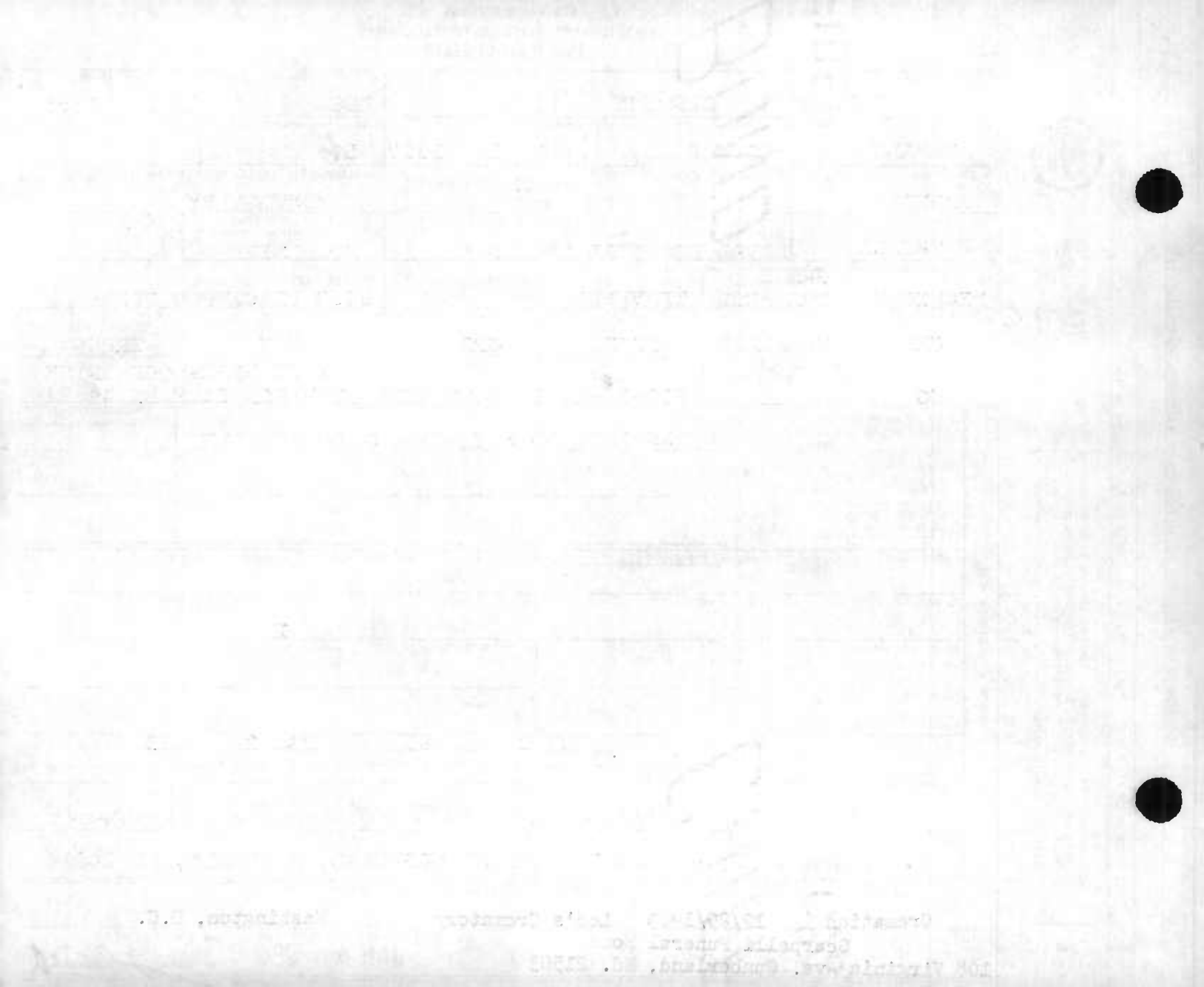
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARYLAND JUSTINA WINN | | | 2a. DATE OF DEATH MONTH DAY YEAR
DEC 28 1983 | | | 2b. HOUR A.
1:55 M | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEP 18 1927 | | 6. AGE (IN YEARS) LAST BIRTHDAY
56 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | |
| 7c. CITY OR TOWN OF DEATH
BETHESDA | | 7d. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL BETHESDA | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
MICHIGAN | | 13b. GRAND
TRAVERSE | | 13c. CITY OR TOWN
TRAVERSE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3452 BLACKWOOD DRIVE 94999 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES FRANKLIN EELLS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ORA MAY IRONS | | | | 16. SOCIAL SECURITY NO.
577-34-1062 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | 17. INFORMANT
JOHN WINN TRAVERSE CITY MI 49634 | | | | 17a. ADDRESS
3452 BLACKWOOD DRIVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF THE LUNG
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOV 3 1983 , to DEC 28 1983 , that (I) (we) last saw the deceased alive on DEC 28 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
L. Durante, LTCUSNR | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
28 DEC 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
L. DURANTE, LT, MC, USNR | | | | | | 22e. ADDRESS
NAVAL HOSPITAL, BETHESDA, MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
12/29/1983 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | |
| 24. FUNERAL DIRECTOR
NAME
Scarpelli Funeral Home | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 4 1984 | | 25b. REGISTRAR'S SIGNATURE
John J. Canfield | |
| 108 Virginia Ave. Cumberland, Md. 21503 | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
John Gardner Wire | | | 2a. DATE OF DEATH
MONTH DAY YEAR
December 14, 1983 | | | 2b. HOUR
M
1:48PM | | | |
| 3 SEX
Male | | 4 RACE
white | | 5 DATE OF BIRTH
MONTH DAY YEAR
April 10, 1938 | | 6 AGE (IN YEARS LAST BIRTHDAY)
45 YRS. | | 7 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10 CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Hardware | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Paul F. Wire | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minnie Gardner | | 13e. STREET ADDRESS
139 S. Van Buren St. Rockville Md. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
----- | | 17 INFORMANT ADDRESS
Paul F. Gardner same as 13e | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c.)
PART I. DEATH WAS CAUSED BY:
1729 IMMEDIATE CAUSE (a) <u>Widespread malignant melanoma</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause lost
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 MONTHS | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> 19 <u>83</u> , to <u>Dec 14</u> 19 <u>83</u> , that (I) (we) lost
saw the deceased alive on <u>Dec 14</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Eugene P. Flannery</u>
EUGENE P. FLANNERY, MD | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12/14/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EUGENE P. FLANNERY, MD | | | | 22e. ADDRESS
18111 PRINCE PHILIP DR.
OLNEY, MD - 20832 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
12/17/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Clarksburg Methodist Church Cemetery, Clarksburg, Md. | | 23d. LOCATION
CITY OR TOWN STATE | | | |
| 24 FUNERAL DIRECTOR
1331 Rockville Pike Rockville, Md. 20852 | | | | 25a. DATE REC'D. BY REGISTRAR
DEC 19 1983 | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Cahill</u> | | | |

afflict =

1120-01-100

CR-51-01

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGE 5 TO YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
|--|--|---|--|--|--|---|--|--|--|--|--|----------|--|
| 1- FOR STATE REGISTRAR | | | | | | 7a. DATE KNOWN OF DEATH | | | | | | 7b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) Elizabeth C. Wooden | | | | | | MONTH DAY YEAR 12 25 19 83 | | | | | | 25 15 M | |
| 3. SEX Female | | 4. RACE Cauc | | 5. DATE OF BIRTH 5 TH 19 ^{AY} 12 ^R | | 6. AGE (IN YEARS) 71 ^{BIRTHDAY} YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D. C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (Suburban Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY none | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5001 R. J. Rd. | | | | | |
| 13a. STATE Md | | 13b. COUNTY Mont. | | 13c. CITY OR TOWN Bethesda | | | | | | | | | |
| 14. FATHER'S NAME George M. Churchill | | | | | | 15. MOTHER'S MAIDEN NAME Mary Solyom | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 579-12-8786 | | 17. INFORMANT ADDRESS Maryland Robert C. Wooden, 5403 Trent St., Chevy Chase | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
4291
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION <u>None</u> | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John P. DeVol</u> M.D. DeVol | | | | TITLE (SPECIFY) MEDICAL EXAMINER | | | | DATE SIGNED Dec 26 1983 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE Dec. 27, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia | | | | | |
| 24. FUNERAL DIRECTOR NAME DeVol Funeral Home, 2222 Wisc. Ave., NW, Wash., DC | | | | 25a. DATE REC'D. BY REGISTRAR JAN 03 1984 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, proper should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) IRVIN N. WRIGHT | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR Dec 27 83 2b. HOUR 1:15 PM | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR June 17 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary Treasurer | | 12b. KIND OF BUSINESS OR INDUSTRY
Nursery | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13e. STREET ADDRESS
304 Mt. Vernon Place 20852 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
E. Nisbet Wright | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
577-05-0432 | | 17. INFORMANT
ADDRESS
John I. Wright Tall Timbers, Md. 20690 | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
0119
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertension
DUE TO, OR AS A CONSEQUENCE OF
(c) Old Pulmonary Tuberculosis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a) | | | | | | | | | |
| 19a. DATE OF OPERATION
11-29-83
12-10-83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Gum Reduction Rt. Hip. | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 26 , 19 83 , to Dec 27 , 19 83 , that (I) (we) last saw the deceased alive on Dec 26 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased did not view the body after death.) | | | | | | | | | |
| 22b. SIGNATURE
Robert T. Thibault DEGREE | | | | | | 22c. DATE SIGNED
12-27-83 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT T. THIBAUDEAU | | | | | 22e. ADDRESS
Rockville, Md. 20852 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12/30/83 | | 23c. NAME OF CEMETERY OR CREMATORY
Monocacy Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Beallsville, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 6 1984 | | 25b. REGISTRAR'S SIGNATURE
John J. Connel | |

BP _____

1. Name of the person or organization to whom the letter is addressed.
 2. Address of the person or organization to whom the letter is addressed.
 3. City and State of the person or organization to whom the letter is addressed.
 4. Country of the person or organization to whom the letter is addressed.
 5. Date of the letter.
 6. Subject of the letter.
 7. Name of the person or organization from whom the letter is received.
 8. Address of the person or organization from whom the letter is received.
 9. City and State of the person or organization from whom the letter is received.
 10. Country of the person or organization from whom the letter is received.
 11. Date of the letter.
 12. Subject of the letter.

13. Name of the person or organization to whom the letter is addressed.
 14. Address of the person or organization to whom the letter is addressed.
 15. City and State of the person or organization to whom the letter is addressed.
 16. Country of the person or organization to whom the letter is addressed.
 17. Date of the letter.
 18. Subject of the letter.
 19. Name of the person or organization from whom the letter is received.
 20. Address of the person or organization from whom the letter is received.
 21. City and State of the person or organization from whom the letter is received.
 22. Country of the person or organization from whom the letter is received.
 23. Date of the letter.
 24. Subject of the letter.



25. Name of the person or organization to whom the letter is addressed.
 26. Address of the person or organization to whom the letter is addressed.
 27. City and State of the person or organization to whom the letter is addressed.
 28. Country of the person or organization to whom the letter is addressed.
 29. Date of the letter.
 30. Subject of the letter.
 31. Name of the person or organization from whom the letter is received.
 32. Address of the person or organization from whom the letter is received.
 33. City and State of the person or organization from whom the letter is received.
 34. Country of the person or organization from whom the letter is received.
 35. Date of the letter.
 36. Subject of the letter.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Theresa Caroline WYMER</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>12/25/83</i> | | | 2b. HOUR
<i>5:50 PM</i> | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>July 28, 1899</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>84</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>West Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>United States</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>MONTGOMERY CO. MD.</i> | | | |
| 10. CITY OR TOWN OF DEATH
<i>BETHESDA, Md.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>SUBURBAN HOSPITAL</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Own Home</i> | | | |
| 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Olney</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>James Blake</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Rebecca M. Stien</i> | | 13e. STREET ADDRESS
<i>4420 Thornhurst Drive</i> | | Zip: <i>20832</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>N/A</i> | | 17. INFORMANT (Daughter)
<i>Phoebe W. Clark</i> | | ADDRESS
<i>4420 Thornhurst Dr
Olney, Maryland</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>pneumonia</i>
4860
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 day</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>April 83 to date</i> | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>12/25/83</i> to <i>date</i> that (I) (we) last saw the deceased alive on <i>12/25/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (did) (did not) view the body after death) | | | | | | | | | |
| 22b. SIGNATURE
<i>Thos G. Ward</i> | | DEGREE | | ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 12/25/1983
208/17 | | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Thos G. Ward</i> | | 22d. ADDRESS
<i>6116 Robinwood, Bethesda Md</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <i>Burial</i> | | 23b. DATE
<i>Dec 29, 1983</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Shenandoah National</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Winchester Virginia</i> | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Robert A. Pumphrey</i> | | | | ADDRESS
<i>Funeral Homes, P.A., Bethesda, Maryland</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>DEC 30 1983</i> | | 25b. REGISTRAR'S SIGNATURE
<i>James J. Gainer</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Carrie G. Young | | | 2a. DATE OF DEATH
MONTH DAY YEAR
12 29 83 | | | 2b. HOUR
10 ³⁵ A M | |
| 3. SEX
Fe | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
11 28 95 | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 8. BIRTHPLACE
(STATE OR FOREIGN)
VA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO MD. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BETHESDA Suburban Hosp. Housewife | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
VA. | | | 13b. COUNTY
Accomack | 13c. CITY OR TOWN
PARKSLEY | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John S. Hinman | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cora Thornton | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
225-922823 | | 17. INFORMANT
Sue Scott | | ADDRESS
4102 GARRISON AVE NW
WASH. D.C. 20016 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
5609 IMMEDIATE CAUSE (a) Vascular collapse
DUE TO, OR AS A CONSEQUENCE OF
(b) Partial Intestinal Obstruction
DUE TO, OR AS A CONSEQUENCE OF
(c) Myocardial Infarction | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12-29-83 to 12-29-83, that (I) (we) lost
saw the deceased alive on 12-29-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Wm Fleet Luckett MD | | | | DEGREE
MD | | 22c. DATE SIGNED
12-29-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Wm Fleet Luckett MD | | | | 22e. ADDRESS
5000 Reno Rd NW | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Liberty | | 23b. DATE
JAN 1, 84 | | 23c. NAME OF CEMETERY OR CREMATORY
Liberty | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
PARKSLEY ACCOMACK VA. | |
| 24. FUNERAL DIRECTOR
NAME
Carl Thornton | | | | ADDRESS
PARKSLEY VA. | | 25a. DATE REC'D. BY REGISTRAR
JAN 09 1984 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John G. Carver | | | |



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20% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HERMAN ZABRONSKY | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
DECEMBER 30, 1983 | | | |
| 3. SEX
male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
4-05-1927 | | 2b. HOUR
11:40 P.M. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MATHEMATICIAN | | 12b. KIND OF BUSINESS OR INDUSTRY
PRIVATE | |
| 13a. STATE
md | | 13b. COUNTY
Mont | | 13c. CITY OR TOWN
Wheaton | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HARRY ZABRONSKY | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
RACHEL FRUMER | | 13e. STREET ADDRESS
10857 Pucknell Dr. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
072-22-9733 | | 17. INFORMANT
ADDRESS
JEROME ZABRONSKY, 185 CHINOOK DRIVE, SYRACUSE, NEW YORK 1321 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brain metastases
1629
DUE TO, OR AS A CONSEQUENCE OF (b) cat cell lung cancer
DUE TO, OR AS A CONSEQUENCE OF (c) 1 mo.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 9 mo. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Hepatic encephalopathy 2° to liver metastases | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 4/1 , 19 83 , to 12/30 , 19 83 , that (1) (we) lost
saw the deceased alive on 12/30 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Peter B. Sherer | | | | DEGREE
MD | | 22c. DATE SIGNED
12/31/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Peter B. Sherer MD | | | | 22e. ADDRESS
3947 Ferrara Dr. Wheaton, md | | | |
| 23a. BURIAL, CREMATION, REMOVAL
SPECIFY
BURIAL | | 23b. DATE
1/2/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
MOUNT LEBANON CEMETERY ADELPHI, PR. GEORGES, MARYLAND | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | 25a. DATE REC'D. BY REGISTRAR
JAN 5 1984 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John J. [Signature] | | | |

BP

